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Interactional Practices in Prenatal Care: Balancing a Medical Agenda with Patient Concerns

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Interactional Practices in Prenatal Care:
Balancing a Medical Agenda with Patient Concerns

A dissertation submitted in partial satisfaction of the

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in Sociology

by

Lisa Ann Kietzer

2018

ABSTRACT OF THE DISSERTATION

Interactional Practices in Prenatal Care:

Balancing a Medical Agenda with Patient Concerns

by

Lisa Ann Kietzer

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2018

Professor Steven E. Clayman, Chair

Studies examining US prenatal care have identified problem screening and information giving as the doctor's main agenda, and receiving information as patients' main goal, however few studies have examined the interactional practices of prenatal care to determine how physician and patient goals and orientations become manifest in the visit and how they are implemented in practice. This study applies the methods of conversation analysis to 30 prenatal consultations to uncover how patients' desires, views, and concerns manifest in discussion, and how the doctor navigates the balance between patient concerns and a medical agenda. An analysis of ultrasound introductions shows how the doctor and her patients index a secondary orientation to the ultrasound as a valid means to satisfy patient curiosity, while simultaneously maintaining a primary orientation to the ultrasound as a medical tool. In addition, both parties may exploit patient curiosity as a cover for medical concerns. Examining different points of future decision

making reveals that the doctor implicates varying levels of patient agency in determining the course of care. These differing levels of agency appear to vary systematically with the type of decision under discussion, apparently owing to patient experience, professional recommendations, and larger cultural attitudes. Finally, the doctor and patients' regular use of particular interactional strategies creates an environment in which worry is obscured or circumvented. This allows for the doctor to monitor the patient and share information with her without triggering alarm. Taken together, these chapters help to elucidate how important prenatal care objectives are pursued with due sensitivity to patient interests and concerns.

The dissertation of Lisa Ann Kietzer is approved.

John Heritage

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2018

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Education

MA, Sociology, University of California-Los Angeles, 2010.

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Humanities and Social Sciences Graduate Career Consultant, UCLA Career Center, October 2016 – June 2017.

Graduate Student Open Access Liaison, UCLA Library, June 2015 – June 2016.

Editor In Chief, UCLA Center for Language, Interaction, and Culture Graduate Student Association, May 2012 – May 2014.

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Research and Practice Support Specialist, Wisconsin Research and Education Network, University of Wisconsin Department of Family Medicine, April 2007 – September 2008.

Study Coordinator, Gynecology Research Office, University of Wisconsin Department of Obstetrics and Gynecology, July 2005 – April 2007.

Associate Research Specialist, University of Wisconsin Postpartum Depression Treatment Program, University of Wisconsin Psychiatric Institute and Clinics, January 2003 – July 2005.

Professional Presentations

"'s Curious: Maintaining a 'worry-light' environment in routine prenatal care." Presented at the 5th International Conference on Conversation Analysis, Loughborough, UK, July 2018.

"'Do you wanna see the baby?: Referencing ultrasounds in prenatal care." Presented at the 112th Annual Meeting of the American Sociological Association, Montreal, QC, August 2017.

"Birth Decisions in Conversation." Presented at the Annual Meeting of the Eastern Sociological Society (Sociology of Reproduction Mini-Conference), Boston, MA, March 2016.

"'Oh, the anger thing?': Naming the Problem in Marital Problem Discussions." Presented at the Sociologists for Women in Society Winter Meeting, Santa Ana Pueblo, NM, February 2013. (Roundtable session.)

"'So what about holidays?': Launching Marital Problem Discussions." Presented at the 107th Annual Meeting of the American Sociological Association, Denver, CO, August 2012.

"Issues in Marital Conversation: Initiating Problem Discussions." Presented at the 81st Annual Meeting of the Pacific Sociological Association, Oakland, CA, April 2010.

1. Introduction

PRENATAL CARE IN THE US

Prenatal care is medical care a woman receives in a series of regular clinical checkups from once she becomes pregnant until the pregnancy ends (through birth, loss, or voluntary termination). The American College of Obstetricians and Gynecologists, the leading professional organization of OB/GYN practitioners, recommends that women with uncomplicated pregnancies receive regular prenatal care on a schedule of one visit every four weeks until 28 weeks, every two weeks until 36 weeks, and then weekly until delivery (American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012b). Visits should include a variety of activities, depending on how far along the baby is:

Initial visit. The initial visit should include a physical exam, lab screening of blood and urine for various conditions (blood type, Rh factor, hematocrit and hemoglobin levels, rubella, varicella, syphilis, gonorrhea, chlamydia, urinary tract infection, hepatitis B, and HIV), a discussion of birth defects screening testing, assessment of depression, domestic violence, and smoking, history taking for pregnancy risk factors such as gestational diabetes, and an ultrasound for establishment of the due date.

All subsequent visits. All visits following should include measurements of weight and blood pressure, a urine test (for protein, glucose, ketones), detection of fetal heartbeat after 10 weeks, and fundal height measurement and fetal movement detection after 20 weeks.

Second trimester (13-26 weeks). Second trimester visits should include screening for gestational diabetes and anemia, assessments for domestic violence and smoking, and counseling for breastfeeding. Additionally, birth defects screening should be offered between

15-20 weeks, and an ultrasound for anatomic assessment should happen between 18-22 weeks (subsequent ultrasounds should only be performed when medically indicated).

Third trimester (27 weeks – delivery). Third trimester visits should include a group B strep test, repeat syphilis, HIV, gonorrhea, and chlamydia testing, repeat domestic violence and smoking assessments, and continued breastfeeding counseling/encouragement. (American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012b)

In the United States, more than three quarters of pregnant women initiate prenatal care during the first trimester (National Center for Health Statistics 2018). Within California, 99% of pregnant women receive prenatal care, with 85% of pregnant women starting in their first trimester, and less than 1% receiving no prenatal care at all. At least 75% of California women receive what is determined to be adequate prenatal care, which starts before the fourth month and includes at least 80% of number of visits recommended by ACOG based on gestational age at the start of care (Kotelchuck 1994; National Center for Health Statistics 2018).

Inadequate prenatal care and lack of prenatal care are well established as risk factors for preterm labor, low birthweight, and infant death (Cox, Zhang, Zotti, and Graham 2011; Krueger and Scholl 2000; Vintzileos, Ananth, Smulian, Scorza, and Knuppel 2002). Yet, its specific medical benefits are unclear, as the profession does not agree on how increased prenatal care leads to better birth outcomes. Debates have been going on for over twenty years (for just one example, see (Steer 1993). Large studies have investigated many possibilities. Some think prenatal care results in decreased maternal smoking, which is known to result in low birth weight (Kramer 1987). Others contend that prenatal care leads to better control of blood pressure, which decreases preterm labor (Vintzileos et al. 2002). Overall, low-income and low-education women

are generally thought to benefit more from initiatives to increase prenatal care use (Partridge, Balayla, Holcroft, and Abenhaim 2012).

Benefits of prenatal care are also questionable when viewed from a socio-cultural perspective. Feminist scholars have argued that the medicalization of birth (which has been studied and critiqued widely) has led to medicalization of reproduction in general, including pregnancy via prenatal care (Franklin 1997; 1998; Martin 2001). One observed consequence of this is a regime of surveillance as a tool for social control, particularly over low-income women and women of color (Humphries, Litt and McNeil). (Humphries 1999; Litt and McNeil 1997). Emphasis on medical technology during pregnancy reinforces patriarchal notions about the relationship between mother and fetus, who are seen as conceptually separate beings, which can result in the mother's rights being overridden by those of the fetus (Katz Rothman 1999; Purdy 1996). Also, medical determination of pregnancy (for example via ultrasonography or blood testing) prior to detection of a viable fetal heartbeat (which typically does not happen before 10 weeks) results in women experiencing the stress of what are now termed miscarriages, whereas previously they would simply have had "missed periods" (Layne 2003).

Still, women overwhelmingly believe that prenatal care is essential (Chalmers, Enkin, and Keirse 1989). Research has demonstrated a widespread belief among parents that, should a problem arise during pregnancy, "the doctor will be able to fix it" (Layne 2003). Prenatal care is also stressed as a source of desired information – women willingly grant access to their bodies in order to learn how they should act and care for themselves during pregnancy, while still remaining somewhat skeptical of the things they are told (Browner and Press 1996). How much control they wish to have over their pregnancies, however, appears to vary by social class, with

middle class women wishing to retain some control, while lower class women neither want nor expect control, being more concerned instead with continuity of care (Lazarus 1994).

RATIONALE FOR CONVERSATION ANALYSIS IN PRENATAL CARE

Similar to much of the research on medical interactions, many studies in prenatal care have used ethnographic observation, which involves subjective interpretation of events, or interviews with doctors or patients, which rely on participant recall. By design, these studies cannot appreciate the nuances in communication as produced by the participants. These methods do not allow for a level of detail that demonstrates interactional complexity, nor do they take into account the interactional context, including consequences of actions. They often ignore or gloss over both the detail of what doctors and patients actually say, and the interactional context in which they say it, or impose researchers' interpretation of events onto the encounter (Heritage and Maynard 2006). Given that, the methods of conversation analysis may prove valuable in investigating the intricacies within prenatal care.

Conversation analysis (CA) is based on directly observable properties of data – the actions participants employ and their consequences. (Drew, Chatwin, and Collins 2001; Heritage and Maynard 2006). It captures on-the-ground perspectives displayed by the members as they co-construct their reality. In this way, CA straddles the boundary between the social science concern with solid, objective research findings concerned with social meaning of events with the humanistic concern of capturing modes of expression and the lived experience of individuals. It is indeed, "the study of life as it is experienced by those who are living it" (Pescosolido et al, 2000).

Conversation analysis emerges from four theoretical assumptions: 1) Social interaction is an organized, structured domain (the "interaction order," Goffman 1983); 2) turns at talk and their components perform social actions that are both context-shaped and context-renewing – because, as Garfinkel noted, the methods for producing social action are also the methods participants use to understand social action (see Heritage 1984); 3) these properties are evidenced in even the smallest minutiae of interaction, therefore no detail is too small, accidental, or irrelevant; 4) examining the sequential organization of interaction enables the researcher to discover the participants' own understandings moment by moment, as their turns at talk will display their understanding of what has come before (Heritage and Maynard 2006). With this method, interactions are compared and analyzed to detail the actions participants perform in their talk, how those actions co-construct the medical visit, and what consequences they have (Drew, Chatwin, and Collins 2001). Building collections of specific practices, the researcher analyzes each collection case by case. Case by case analysis allows for identification of normative patterns and deviant cases, which help identify parameters of interactional norms (Clayman and Gill 2004).

Applying conversation analysis to medical encounters keeps the focus on what doctors and patients do and experience in the moment. Given its basis in Goffman's interaction order and Garfinkel's methods of commonsense reasoning, CA presumes that doctors and patients continually co-construct the medical encounter, no matter how minimal any given contribution appears. And, since communication focuses primarily on the joint management of self-other relations (Goffman 1955), as doctors and patients co-construct the encounter, they co-construct their very relationship. Focusing on participants' shared understanding, as displayed in their talk, CA allows us to track, in the moment, how care is co-constructed in the medical encounter. With

this enhanced understanding of how the doctor-patient relationship is enacted moment by moment, we can begin to understand to what extent doctors grant patients agency in their care, and what consequences that has for the prenatal care visit.

Application of CA to prenatal care has been extremely limited so far, with the only examples coming out of Japan, focusing on ultrasound examination and problem presentation (Nishizaka 2011a; Nishizaka 2011b; Nishizaka 2013; Nishizaka 2014a; Nishizaka 2014b). However, previous CA work in other medical contexts has demonstrated its expansive value in exploring the intricacies of medical interaction. These studies have resulted in significant insights in three areas in particular:

Openings. Work focusing on the openings of medical visits has shown how patients illuminate the social norms and practical concerns that patients bring into the encounter, and how these norms and concerns shape their presentation of the problem that brought them to clinic (Heritage and Robinson 2004). This work has resulted in insights into how patients talk about their troubles in a medical setting (as described by (Jefferson 1984)), and how they seek and achieve validation from the doctor.

Diagnostics. Doctors have multiple strategies for producing diagnosis (Heath 1992; Perakyla 1998), though they often struggle when the diagnosis involves bad news (Maynard 2003). Doctors also may foreshadow "no problem" diagnoses by providing commentary on observations gathered during exams (Heritage and Stivers 1999).

Treatment recommendations and response. Through work in this area, we have learned that doctors use a variety of recommendation formulations to index varying levels of authority and patient agency (Stivers, Heritage, Barnes, McCabe, Thompson, and Toerien 2018). Doctors may set the scene for compliance by using preliminary sequences that

precede the actual treatment recommendation and put more pressure on the patient to agree (Barnes 2018). Patients, on the other hand, can exhibit resistance to doctors' recommendations, resulting in a "tug of war" between them (Gill 2005; Stivers 2007). Patients can also apply pressure to doctors for certain treatments, which doctors can resist (Stivers 2007).

Using previous studies like those above as an analytic framework, this study seeks to provide a complement to the few existing CA studies in prenatal care by analyzing interactions between a doctor and her pregnant patients. This study seeks to build on the larger medical CA canon to contribute new insights into the interactional processes that comprise prenatal care.

THE PRESENT STUDY

When the doctor in these data was asked by a patient (24 weeks pregnant at the time) what the purpose of her visit that day was, the doctor gave this statement as an answer:

> "We usually see women every month during the first part of the pregnancy to make sure they're gaining weight properly, to make sure that they're not having any trouble with vaginal bleeding, to give them a chance to do some advance planning for things like contraception, what hospital you're gonna go to, who is gonna help you when the baby's born, to talk about any issues you may have that have come up, vaginal discharge, you're not feeling the baby move and you're worried about it, you're having shortness of breath or trouble sleeping or urination problems, whatever they may be. There isn't anything you can really do during a visit that changes the outcome of the pregnancy. So, the purpose of prenatal care is both educational, to prepare you for having the baby, and screening. And what we're screening for mostly in prenatal care are problems with the mom. So if mom has persistent nausea and vomiting in pregnancy and she's not gaining weight properly or if she's gaining too much weight, or if her blood pressure starts to go up, or if we do those tests which we repeat those tests again later in the pregnancy and she develops diabetes, or she develops anemia, so that's really the purpose of prenatal care. It can't change what the baby is. And there is no test that is 100 percent effective, or accurate, at saying whether the baby has a problem."

According to this doctor, then, prenatal care has two main purposes – to educate the mother, and to monitor her for problematic conditions. The doctor's agenda (screening and education) has

entirely justifiable medical aims, but it also has the potential to generate local interactional problems. Education-based interventions on mothers' behavior – the pursuit of lifesteyle changes, vaccinations, etc. - is intrinsically burdensome and may be regarded as intrusive. And the various medical procedures necessary to screen for problems can stimulate concern and outright worry on the part of patients.

Against this backdrop, how do doctors navigate these various dilemmas in prenatal care?

Further, what do these considerations mean for patient participation in the encounter? With the assumption patients wants to become informed and are willing to grant access to their bodies to do that (Press and Browner 1997), do patients give up all control, and acquiesce to the doctor, who acts authoritatively? Or do patients still have agency? Do patients have desires outside of gathering information, and if so, what are they and how do they manifest? The problems the doctor mentioned could be worrisome to the patient – do patients communicate worry?

This study will attempt to shed light on these questions by analyzing interactions within prenatal care via three focal points: 1) introduction of the ultrasound, 2) broaching discussion of future points of decision, and 3) mitigation of worry via construction of tests and procedures.

Chapter 3 investigates the introduction of the ultrasound in conversation. Both the doctor and the patient may initiate ultrasound discussions, and the strategies they use are described. Analyses of these introductions reveals that both parties orient to the ultrasound as a medical tool primarily, but a secondary orientation to the ultrasound as an activity to satisfy patient curiosity exists simultaneously. In addition, the secondary orientation can be used to mask medical concerns.

Chapter 4 explores the shaping of future decisions by comparing the introductions of three topics: a breastfeeding class, birth control after delivery, and the pertussis vaccine. Except in the case of birth control, which the patient will sometimes bring up first, the doctor always intitates discussion. Data excerpts demonstrate that she varies her introductions systematically in ways that implicate varying degrees of patient agency in the different decisions, apparently owing to patient experience, professional recommendations, and larger cultural attitudes.

Chapter 5 explores the apparent mitigation of worry in the introduction, process, and review of routine prenatal procedures and testing. Analysis shows that recurrent features used by both the doctor and the patients serve to routinize the activities and assuage potential concern via information giving, creating a “worry-light” environment.

Chapter 2. Study Population, Data, and Methods

STUDY SETTING AND POPULATION

Data were collected in a Federally Qualified Health Center (FQHC) obstestric and gynecology clinic in south central Los Angeles. FQHC is a designation given to clinics that provide comprehensive care to all patients, regardless of their ability to pay, in exchange for federal reimbursement. As such, this clinic sees a much higher proportion of uninsured or publicly-insured patients than a non-FQHC clinic. The clinic is located in one part of one floor of a multistory office building, and has a waiting room, records room, nursing station, lab, meeting room (also where classes and the "Centering" groups are held), administrative office, and four exam rooms. The clinic is staffed by one doctor (the study participant doctor), one nurse midwife, various medical assistants and reception staff, and a Clinic Director (who also fields patient questions regarding billing and insurance).

The study doctor, an MD with over twenty-five years experience, also serves as Chair of the Maternity Department at one of the hospitals in the area. The doctor splits her week between seeing OB/GYN patients in clinic (three and a half days per week), delivering babies (one day), and performing surgery (one half-day).

24 distinct (non-high risk) patients consented for this project. They ranged in age from 18 to 38, with an average age of 25. Six patients volunteered their race as white, six as African American, eight as Filipino, and one as Other Asian[1]. 14 patients also claimed Hispanic heritage. Only one patient held private insurance at the time of data collection; all others were on some form of Medicaid. 10 patients were experiencing their first pregnancy; all others had been pregnant at least once before (and all of those except one had successfully delivered at least one

[1] For this study, I used Census race and ethnicity categories on an information sheet that patients filled out themselves. 3 did not volunteer race.

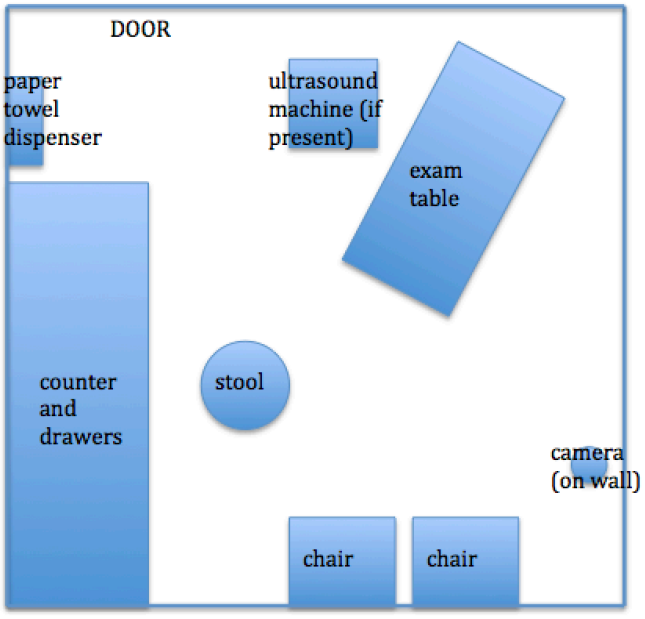
baby before). Six patients had experienced at least one pregnancy loss prior to this pregnancy. Six patients were new to this clinic and this doctor at the time of their (first) study visit. Basic patient data is summarized in Table A.1, located in the Appendix. 19 patients were captured at only one visit. Four patients were captured twice, and one patient was captured three times.

DATA

Data are 30 video recordings of the patient's consultation(s) with the study doctor. Patients were selected for this study using very basic inclusion criteria: at least 18 years of age, pregnant, and here to see the study doctor.[2] The recording starts when the doctor enters the exam room, and ends when the doctor and patient (and companion/s, if applicable) leave the exam room. Prior to seeing the doctor, the patient will have checked in at the front desk, and may have had a blood draw in the lab or been asked for a urine sample.

The exam room was set up as indicated in Figure 2.1:

Figure 2.1. Exam room layout



[2] As the video camera for the study was affixed to the wall in only one exam room, the very kind and helpful clinic staff roomed the doctor's pregnant patients in that room, in case they consented to be in the study.

The data include 27 standard prenatal care checkups, two confirmations of first trimester pregnancy loss, and one termination discussion (that patient ultimately kept the pregnancy, and was subsequently captured two more times as well at regular checkups). Gestational age at time of visit ranged from four to 37 weeks (losses excluded), with an average gestational age of 21 weeks. Variance in gestational age resulted in 8 first trimester, 15 second trimester, and 7 third trimester visits. 10 visits involve at least one companion present with the patient (typically the patient's mother, a romantic partner, or a friend), for the remaining 20 visits, the patient was alone. Visit length ranged from 6.5 minutes to 23.4 minutes, with an average visit length of 12 minutes. Basic visit data is summarized in the Appendix in Table A.2.

METHOD

This study uses conversation analysis (CA) (Clayman and Gill 2004; Heritage 1984b; Heritage and Maynard 2006; Schegloff 2007) to illuminate the interactional nuances within prenatal care. CA identifies the "what and how" necessary to understand processes that underlie quality and effectiveness of care by identifying sequential patterns of social action, and the communicative practices through which these patterns are generated (Drew, Chatwin, and Collins 2001). With this method, the interactions are compared and analyzed to detail the actions participants perform in their talk, how those actions co-construct the medical visit (Heritage and Maynard 2006), and what consequences they have (Drew, Chatwin, and Collins 2001).

CA contains three unique theoretical premises: 1) Talk produced is understood to be performing social actions, and larger activities (such as history taking or presenting treatment options) are composed of these actions; 2) Actions are connected in sequences, so that the actions of one participant are generated by and dependent on what another participant has done, implying that actions cannot be analyzed independently of their interactional context; and 3)

Sequences appear to have stable patterns, in that one action performed by multiple people independently of each other can be shown to result in similar responses by other participants (Drew, Chatwin, and Collins 2001). Its application here to medical care imposes assumes additional constraints, characteristic of talk within institutions, including: 1) participants have specific goal orientations tied to their relevant identities (doctor and patient), 2) there are special constraints on what is treated as allowable contributions to the business being conducted, and 3) the institution imposes a specific inferential framework through which actions are interpreted (Drew and Heritage 1992; Heritage and Clayman 2010).

CA hinges on the concept of turn design: Participants take turns speaking, and have choices in how to construct their turn at talk (Clayman 2012; Drew, Chatwin, and Collins 2001; Drew 2012). How they choose to construct their turn results in a specific action that will be responded to by other participants. This means that turns that are even slightly different from one another will have different sequential consequences, as responses are connected directly to how the previous turn is constructed (Drew, Chatwin, and Collins 2001).

Prior to analysis, a handful of visits were transcribed using Jefferson transcription notation (Jefferson 2004). Jeffersonian transcription is finely detailed to allow for examination of interaction down to the microsecond, including pauses, inbreaths, elongation of sounds, cutoffs, and other characteristics of speech delivery (Drew, Chatwin, and Collins 2001). Then, a preliminary analysis was done on those consultations. After identifying critical points of interest, I then identified similar junctures in the remaining consultations, and fully transcribed those instances as well. In this way, preliminary analysis guided later full transcription, and I built collections of cases of specific interactional practices related to patient agency and initiative within prenatal care, and the sequences they were embedded in.

Following transcription and collection building, data were analyzed using the methods of conversation analysis (Clayman and Gill 2004; Heritage 1984b; Heritage and Maynard 2006; Schegloff 2007). Taking my collections of specific practices, I analyzed each collection case by case. Case by case analysis allowed me to determine normative patterns and deviant cases, which helped identify parameters of interactional norms (Clayman and Gill 2004). In the vein of analytic induction (Katz 2001), I worked systematically through collections to identify patterns within practices, from which I developed objective generalizations that encompass all (or most) cases within patterns, thereby generating detailed descriptions of a set of key practices. I then analyzed the consequences of these practices by examining their immediate responses and their effects on the larger activity in progress and the interaction overall. This resulted in a comprehensive descriptive analysis of key interactional behaviors and their consequences.

Chapter 3. "Do You Wanna See the Baby?": First Mentions of Ultrasound in Prenatal Care

The frequent use of ultrasound examinations during prenatal care is somewhat controversial. The American College of Obstetricians and Gynecologists (ACOG) notes that ultrasounds are not associated with risk and are useful diagnostic tests, but their use should be prudently limited to cases where there is a relevant clinical question (American College of Obstetricians and Gynecologists 2017b). However, ACOG does not provide specific recommendations for exactly how many ultrasounds should be performed during a pregnancy, or how frequently they should occur, other than to say that a pregnant woman should receive "at least one" at 18-22 weeks gestation (American College of Obstetricians and Gynecologists 2017a).

Physicians consider ultrasounds an "invaluable third eye" (Edvardsson, Small, Persson, Lalos, and Mogren 2014) aiding them in surveillance and care management. They frequently rely on them to reassure the patient, yet also note the potential for them to cause the patient unnecessary anxiety (Edvardsson et al. 2014), (Simonsen, Branch, and Rose 2008). For their part, patients view the ultrasound as a means to achieve a variety of goals, including bonding with the baby and being an active participant in their care, as well as a way to receive reassurance (Molander, Alehagen, and Berterö 2010). Indeed, pregnant women have higher expectations for ultrasounds than can actually be met, due to the limitations of the technology, although they often perceive them as having been met (Lalor and Devane 2007).

Unsurprisingly, then, a recent US national survey of women's childbearing experiences showed that ultrasound use often exceeds the vague official recommendations, with 70 percent of mothers reporting having had three or more ultrasounds during pregnancy, and 23 percent reporting six or more (Declercq, Sakala, Corry, Applebaum, and Herrlich 2013). But no studies

have examined exactly how they come to happen in the co-construction of the patient visit. Previous conversation analytic work by Nishizaka examining prenatal ultrasounds has focused on the procedure itself (Nishizaka 2011a; Nishizaka 2013; Nishizaka 2014a; Nishizaka 2014b), but not on the discussions that give rise to the ultrasound.

This chapter analyzes the first mentioning of the ultrasound, in visits where ultrasounds occur, to see how it is treated in discussion. At a quick glance, it appears that both the patients and the doctor regard the ultrasound as something done for the patient's personal benefit (or to satisfy her curiosity) some of the time, while at other times, they regard it as a medical tool. But closer analysis reveals the primacy of a medical orientation that occurs often simultaneously with a secondary orientation for the patient's benefit.

The analytic sample for this chapter is comprised of 18 clinic visits that include an ultrasound performed during the visit. I focus on the initial mentioning, by either the doctor or the patient, to determine not only who brings up the ultrasound, but how. (Two visits that also contain ultrasounds have been excluded from this sample, as the ultrasound was mentioned before the video for the visit began.) For the transcript excerpts in this chapter, headings indicate the following relevant information:

Line 1: Visit # (weeks gestation), if companion present, new or returning patient
Line 2: Physical orientation of individuals in room at start of excerpt
Line 3: Ultrasound machine status: present in room or not, turned on or off
Line 4: Time elapsed in visit at start of excerpt

Example:

```
006-02 (11 wks), companion present, return pt
pt seated on table, comp in chair, doc standing at table
US machine present, off
3:52
```

Analysis shows a predominance of doctor-initiated introductions over patient-initiated introductions of the ultrasound. This predominance, combined with the mostly medical reasons

the doctor cites for performing an ultrasound, treat the ultrasound primarily as a medical tool. However, patients occasionally initiate discussion of the ultrasound themselves, in the form of a request. The doctor sometimes also treats the ultrasound as motivated by patient interest rather than medical justification. Additionally, the doctor will often frame the introduction of the ultrasound as an offer or as a proposal for joint activity. These aspects suggest another orientation towards the ultrasound as an optional activity done for the patient's enjoyment or to satisfy her curiosity. But these aspects are less frequent, often mitigated and/or overshadowed by medical justification, and possibly a mask for actual medical concerns that are revealed later in the visit. Therefore, while both parties can enact a view of ultrasounds as something done for the patient's benefit, they still primarily treat the ultrasound as a medical tool.

PRIMARY ORIENTATION: IMMEDIATELY OBVIOUS MEDICAL RELEVANCE

Medical reasons evident in doctor-initiated introductions

In the overwhelming majority of visits in this sample, the doctor introduces the idea of performing an ultrasound (15 of the 18 cases). In 11 of those 15 cases where the doctor introduces the ultrasound, a medical justification has arisen in the ongoing discussion or activity of the visit, serving as a preliminary to the ultrasound proffer (Barnes 2018). Table 3.1 below emphasizes the predominance of both doctor-initiated discussions and medical justification:

Table 3.1. Ultrasound initiation characteristics

Analytic sample - 18 ultrasounds:	
15 introduced by doctor	3 introduced by patient
4 out of the blue	2 explicit requests
3 "see baby"	gender + "see baby"
1 no reason	1 implicit request
11 arising from discussion	gender
all medical reasons	

Reasons the doctor cites include: checking physical orientation of the fetus (head down vs. breech), checking for fetal heartbeat, not having a previous ultrasound report available, determining gestational age, and confirming pregnancy loss.

Fetal positioning. In 024-01, the doctor notes during chart review that, at the time of the previous visit, the fetus had been in breech position. She then brings up ultrasound as a way to check to see if the baby has changed to a head-down position.

Excerpt 3.1

```
024-01 (32 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
US machine present, on
0:52
01 Doc:     So it got better, and then it go[t worse.
02 Pat:                                     [Y e a h.]
03          (0.5) ((Doc nods, looks back in chart, paging through))
04 Doc:     Okay. I'm looking to see what-tah testing she had
05          done before, .hh a::nd,
06          (8.0) ((Doc paging through chart))
07 Doc:  -> You had been breech when you'd had your last
08       -> ultrasound did you want us to check and see if the baby's
09       -> still upside down?
10          (0.5) ((Doc still looking down at chart))
11 Doc:  -> Or if it's flipped around?
12 Pat:     Yeah.
13 Doc:     Okay we can do that real quick, ((looks to companion))
14 Com:     Yeah. Which I think we (have done). I mean, we were
15          thinking of: maybe it has,
16 Pat:     Cause I feel the baby
17          down [here, ((gesturing on belly))
18 Doc:          [Ah[: you feel it down ther[e, okay,]
19 Com:             [(Yeah that's:)         [ Ye:ah, ]
20 Doc:     W'llet's measure your belly and let's listen to the
21          heartbeat and then we'll check and see where the
22          baby is.
23 Pat:     Okay.
```

In this example, the doctor mentions the ultrasound fairly early in the visit. The doctor, who is standing leaning against the counter facing the patient, has been reading the chart while talking with the patient. The doctor narrates her activity as she looks in the chart to see what testing the clinic's nurse midwife had performed at the patient's last visit. The doctor then notes that the baby had been reported to be breech at the time of the last ultrasound. This patient is

currently at 32 weeks, or only five weeks from being considered term. As the patient gets closer to term, positioning of the fetus will become crucial, as a fetus that remains in breech position (where the baby is head-up inside the uterus instead of head-down) would result in a complicated birth. Although there are several weeks left to go, the doctor asks if the patient wants "us" to "check" to see if the fetus was still breech or if it had "flipped around" in the meantime. Given that the previous ultrasound had just been evoked, here the phrase "check and see" is understood to mean doing another ultrasound, to obtain current visual evidence of the baby's position.

In 008-02, the doctor responds to the patient's request to "measure" fetal position, but then adds an offer for ultrasound, even though the patient does not appear to be pursuing an ultrasound specifically:

Excerpt 3.2

008-02 (34 wks), no companion, return pt
pt seated on table, doc seated in chair facing pt
US machine not present
0:00
01 Doc: 've you been the last two weeks.
02 Pat: U:m, I've been okay, ((pt settling onto table))
03 Doc: Yeah?
04 Pat: Yeeah.
05 (0.3)
06 Doc: Any questions or problems?
07 Pat: Nnh, no questions or prah- ((mumbled)) Wah'I ((well I))
08 jus wanted to know when you measure if the baby
09 was head down already or not. I w[ant you tuh .hh]
10 Doc: -> [Okay. So I'll]=
11 Pat: =[measure, °yea°]
12 Doc: -> =[measure, we'l]l take a feel, [uhm I'll l]isten to
13 Pat: [° Okay . °]
14 Doc: -> see where the heartbeat is,
15 Pat: Okay.
16 Doc: -> And if you wanna know we can do an ultrasound,
17 Pat: Okay.=
18 Doc: =But- you:'ve still got six weeks tuh go.
19 Pat: Right.
20 Doc: So even if the baby's head down today?
21 Pat: M-h[m,
22 Doc: [It can flip, around.

The patient frames her wondering in terms of "measuring" if the head is down or not, and then explicitly states her wish for the doctor to "measure." The doctor agrees to this readily,

coming in in overlap with the patient's request and ending simultaneously on the repeated verb "measure." The patient adds a "yea," indicating the doctor has responded in the way she wanted. The doctor continues with elaborating of what "measuring" to determine the baby's position might entail, first with "we'll take a feel," which gets a quiet but final-intoned "okay", and then right on with "uhm I'll listen to see where the heartbeat is," implying that listening to the heartbeat could also provide evidence as to the baby's physical orientation. Both "taking a feel" and listening for fetal heartbeat appear to be adequate enough measures to satisfy the patient, as she responds clearly and outright, again with final intonation, "Okay" in line 13. But even though the patient appears to be satisfied with the prospect of feeling and listening, the doctor continues by invoking the ultrasound as the definitive method – "And if you wanna know" suggests that the previous methods mentioned, while useful, might not be definitive, but this one will be. The patient does agree to the ultrasound by repeating her final-intoned "Okay" in line 17, but makes no indication that she was interested in ultrasound over any other method to determine her baby's position. Therefore the doctor offers an ultrasound as a more accurate way to determine fetal positioning, even though – as she herself notes afterward –it still might not even matter what position the baby is in on this day, as it could still "flip around" in the womb prior to term. (Her qualification of the possible irrelevance of the offered ultrasound here stands in contrast to the previous example, where the patient had even more time to wait within which the fetus might "flip around.")

Fetal heartbeat. In 001-03, the doctor again invokes the ultrasound in response to the ongoing discussion and activity. Here, she has been attempting to listen to the baby's heartbeat via fetal Doppler:

Excerpt 3.3

001-03 (11 wks), no companion, return pt (can't hear HB)
pt laying on table, doc at table

```
US machine not present
5:09
01 Doc:     Let's see if we can hear anything.
02          (2.6) ((doc searching for HB with doppler))
03 Doc:     Maybe, maybe not?
04          (11.0) ((doc still trying to find HB))
05 Doc:  -> If I can't hear it, we'll grab an ultrasound
06       -> BACK, .hh [hh .hh] ((quiet laugh))
07 Pat:                [ Okay.]
08          (10.2)  ((doc still searching for HB))
09 Doc:     A:rright. Lemme (put ya         ) lemme grab
10          an ultrasound real quick. [Okay?] ((leaves room))
```

In this example, the doctor is having trouble hearing the baby's heartbeat using a Doppler device. She then introduces the idea of performing an ultrasound as a way to detect heartbeat if she continues to have trouble. As ascertaining fetal heartbeat is a standard part of prenatal care, here the ultrasound would substitute for the Doppler, thereby serving a medical purpose. At this time there is not an ultrasound machine in the exam room, which is why she mentions having to "grab one back," meaning retrieve one from another exam room (as the clinic does not have enough ultrasound machines to be able to keep one permanently in each of its four exam rooms).

No previous ultrasound / needs baseline ultrasound. Next, we see the doctor broach performing an ultrasound after ascertaining that the patient did have one done at an earlier visit at another clinic (which this doctor does not have records from):

Excerpt 3.4

```
019-01 (17 wks), companion present, return pt
pt seated on table, comp in chair, doc seated at counter
US machine not present
4:40
01 Doc:     You can avoid this? Okay? .hh Let's listen to the
02       -> baby's heartbeat for a minute, did you get an
03       -> ultrasound during the pregnancy?
04 Pat:     Um: only one.
05 Doc:     Only one?
06          (0.6) ((Pt nods, doc in chart))
07 Doc:     °Okay.°
08          (2.4) ((Doc rises, sets chart on counter))
09 Doc:     Go ahead and lie back, let's listen to the heartbeat.
10 ((30 seconds – discuss movement, listen to heartbeat via Doppler))
11 ((Doc grabs paper towel and walks to table, wiping off Doppler))
12 Doc:     Did anyone check something called a hemoglobin A one C?
13          When you were (.) first pregnant?
14 Pat:     I don't think so, ((shakes head))
15 Doc:     You don't think [so.
```

```
16 Pat:                      [Oh:, well they did draw my blood.
17          An:d, but I don't think I: they had given me the-
18          uh: results [for  that]
19 Doc:  ->             [Did you w]ant a quick ultrasound today?
20 Pat:     Yes.  ((smiles))
21          (0.6) ((Doc moves light and pulls curtain to get to door))
22 Doc:     Hang on a second let me get the machine.
23 ((45 seconds — Doc exits, pt and friend react to HB while doc gone))
24 ((27 seconds — Doc enters with machine, preps it and pt silently))
25 Doc:     Let's take a ⇧peek, I'm gonna turn the lights off,
26          (0.6) ((Doc turning off lights))
27 Doc:     So when you said you only had one ultrasound during
28          the pregnancy, when was that one,
```

This patient is not new to this clinic, having participated in the "Centering" group (group prenatal care visits, led by a counselor), but this doctor has never seen her before. The patient is seeing the doctor because the Centering group leader had concerns regarding her recent diagnosis of diabetes, and wanted the doctor to see her. The patient has also had an initial prenatal visit elsewhere, prior to switching insurance. Nearly five minutes in to the visit, most of the discussion so far has been regarding the patient's diabetes, which the doctor finds concerning given that the patient is only 18 years old. As the doctor transitions out of the diabetes discussion, she initiates checking the fetal heartbeat via Doppler, and begins to ask questions regarding what the patient's previous prenatal visit entailed. First she asks about hemoglobin A-1C, and when the patient replies she didn't think she'd had that checked, the doctor registers understanding by repeating her phrasing with "You don't think so." The patient appears to interpret this as an indication that the doctor needs more explanation, so she begins to clarify having had her blood drawn but not receiving any results. Before she is finished, the doctor cuts her off with "Did you want a quick ultrasound today?" In the context of the discussing the patient's previous care, here the ultrasound is treated as something that might be expected to happen during a prenatal care visit. Therefore the fact that one had not yet been done at this clinic can be reason enough to justify performing one as a baseline.

In one interesting case, 026-01, the doctor actually begins interacting with the ultrasound machine before ever even mentioning the ultrasound, making it obvious that she intends to perform one. Yet, she still does interactional work to index medical reasons for performing.

Excerpt 3.5

026-01 (21 wks), no companion, new pt
pt seated on table, doc at US machine entering data
US machine present, on
0:30

```
01 Doc:     So were they able to do anything at Imperial
02          bloodwork er:: a pap test or anything like that?
03 Pat:     No pap, they did, uh: take some bloo:d, b'that
04          was about it,
05       -> (1.2) ((Doc at US machine, pt looks to doc))
06 Doc:     Okay and did they do an ultrasound?
07          (0.2) ((Doc steps back from machine))
08 Pat:     No I didn't get that far. ((shaking head))
09 Doc:     Y'didn't get that far.
10 Pat:     Mm, ((shaking head))
11 Doc:  -> So can we do an ultrasound real quick today to
12       -> get an idea as to how far along you are?
13 Pat:     Yes.
14 Doc:     Go ahead and lie back.
```

In 026-01, similar to 019-01, the patient is new to this clinic. The doctor again asks about the care received at the other clinic and makes performing an ultrasound at this visit relevant. This excerpt is unique when compared to the previous ones in that, when the visit starts, the doctor moves immediately to the ultrasound machine and begins entering information into it. The doctor continues interacting with the machine the entire time while talking to the patient, up to and including this excerpt, which occurs 30 seconds into the visit. Given that she is already interacting with the machine, it would be reasonable to infer from her physical actions alone that she intends to perform an ultrasound during this visit.

The patient received earlier care in her pregnancy during one clinic visit at another health system (here named "Imperial"). The doctor has not received any paperwork from Imperial, so she begins the verbal consultation by asking the patient about what all happened at her Imperial visit. As the patient is at 21 weeks gestation, it is possible that she would have had an ultrasound

at Imperial. The doctor asks about this at line 6, and the patient replies that she "didn't get that far." Given that, the doctor requests to perform one now, prefaced with "so" to indicate the idea being a consequence of not having one from Imperial. In the context of discussion of the patient's previous care, here the ultrasound is treated as something that might have (should have?) happened before, so the fact that one had not already been done might be reason enough to justify performing one as a baseline. But the doctor also appends a concrete medical reason, determination of gestational age, to the end of her request: "to get an idea as to how far along you are."

Gestational age. The link between ongoing discussion and introduction of the ultrasound may be subtler than the above examples. In 021-01, the doctor again mentions confirming gestational age as the reason for doing an ultrasound in lines 36-37, but it comes on the heels of a discussion about time elapsed between the previous birth and this pregnancy.

Excerpt 3.6

```
021-01 (18 wks), no companion, new pt (how far along)
pt seated on table, doc at counter with chart
US present, on
1:38
01 Doc:  -> So- (.) we- (.) encourage people to have at least a
02       -> year and a half? B[etween] delivery one baby and
03 Pat:                        [M — hm],
04 Doc:  -> delivery of the next baby.=So, (.hh) i:t'll (0.4) be:::
05       -> close to tha:t,
06          (0.4)
07 Doc:     Ah:m,
08          (1.6)
09 Doc:     But it's still a lot of work on your body.
10 Pat:     mYeah.
11 Doc:     S:o, y'also (.) still have,
12          (0.6)
13 Doc:     Little one at home.
14          (0.6)
15 Pat:     [ °Yes:° ]
16 Doc:     [I deya-] I: I looked at my records and thought you had
17          only the:
18          (0.8)
19 Doc:     Middle one, bu[t you ac]tually have another[r little one,]
20 Pat:                   [ Ye:ah, ]                   [I have a  lit]=
21          =tle bay- Yeah. She just turned one in May.
22 Doc:  -> Yeah. So yo[u got pregnant befo]re it was even a full year.
23 Pat:                [ .hh    I   know:: ]
```

```
24          (0.3)
25 Doc:  -> Since she was born.
26 Pat:     [°M-hm,°]
27 Doc:     [  .hh ]So you need to be super cautious and make sure
28          that you: get enough protein in your diet,
29 Pat:     M-h[m,
30 Doc:        [enough calcium, enough re:st, enough iron, .h cause
31          those are all things that the baby who just turned
32          one has- taken from you?
33 Pat:     Yeah,
34 Doc:     .h And that this baby deserves to have.
35 Pat:     Okay.
36 Doc:  -> >So let's take a quick ultrasound see how far along
37       -> you are go ahead 'n' lie back< (right) and I'll put
38          the lens cap on when we get to the (p     ) ((table noise))
39 Pat:     Okay.
```

This patient is new to this clinic, and this is her first time being seen for this pregnancy (at 18 weeks). Although she is new to the clinic, she has been pregnant before, having given birth three times previously. This pregnancy has happened relatively soon after her most recent birth, prompting the doctor to explain why the medical profession recommends waiting at least 18 months between births. At the beginning of this excerpt, most of the discussion so far has been regarding the timing of this pregnancy and caution around it. So far, discussion has proceeded with the assumption that the due date provided by the patient (which she based on her last period) is accurate. Although the doctor may want to confirm the due date more accurately, she has not referred to the due date or indicated she might be skeptical of the candidate due date provided by the patient. However, the inference in timing she makes in lines 22 makes accurate confirmation of the due date relevant. In this way, her "so let's take a quick ultrasound and see how far along you are" at line 36-37 is hearably justified via the concerns expressed so far (and also neatly saves face for the patient should it turn out that the due date she provided is incorrect, which it turns out to be).

Pregnancy loss. Sadly, not all pregnancies make it to term. Confirmation of pregnancy loss is another justification for performing an ultrasound, as seen in 003-01.

Excerpt 3.7

003-01 (1st trimester loss), companion present, returning pt
Pat seated on table, comp seated in chair next to table, doc entering
US machine being brought in by doc as she enters

```
0:00
01 Doc:     Hey, how are you guys.
02 Pat:     We're good, h[hh
03 Doc:                  [Thanks for coming back in, I know
04          you're a little bit nervous, I'm gonna have to ask
05          you to move, cuz I need to plug this toy in. ((to comp))
06 Com:     Hhh!
07          (0.6) ((Doc wielding machine, companion rising off camera))
08 Doc:     That actually means move the chair,
09 Com:     Yes.
10 Doc:     If you can move it over to there, that'd be perfect.
11          (0.8) ((Companion moving chair and self across room))
12 Doc:     So any spotting, cramping, any problems since I saw
13          you last?  ((Doc plugging in machine next to table))
14 Pat:     Uh:: since that last spotting no but, I took three tests,
15          an: it said negative.  ((Comp now seated against wall))
16 Doc:     Well: if you took three tests and it said negative
17          then it's negative.
18 Pat:     Yeah, figured that. hh
19 Doc:     Uhm:,   ((Doc stands ahead of patient, looks in chart))
20          (0.8)
21 Doc:     So how are you feeling. About that,
22          (1.0)      ((Doc leans back against counter))
23 Pat:     Mm::, nhh!
24          (1.0)    ((Doc pages through chart))
25 Pat:     Disappointed, I guess,
26 Doc:     Okay,  ((Nodding while looking in chart))
27          (2.0)
28 Pat:     Bu:t, I been through it once already so,
29 Doc:     Okay,
30          (0.4)
31 Doc:  -> .hh Uh:m, do you want me to do an ultrasound
32       -> take a look? °Yeah okay.° ((pt nods, doc reaches machine))
33          Let me just turn this on.
34          (1.0) ((Doc flips swtich on machine))
35 Pat:     I don't have to get undressed do I,
36 Doc:     No.=  ((leans back against counter again))
37 Pat:     =Okay.
```

In this example, the doctor brings in the ultrasound machine as she enters the room, and asks the partner to move so she can plug it in, which strongly suggests an intention to use it during this visit (although she does not also turn the machine on). The couple present has booked the appointment to confirm their suspicions that they have lost the baby. The patient had been seen earlier to discuss spotting (referenced by the patient in line 14), and she reports that since then, she has taken three at-home pregnancy tests, and all three have shown negative results

(lines 14-15), leading her to believe she is no longer pregnant. The doctor agrees with the patient's reasoning in lines 16-17, and asks how the patient is feeling about the likely loss. Looking through the patient's chart, the doctor offers no additional assessment of the patient's reported reaction. She then asks if the patient would like her to perform an ultrasound to "take a look" (lines 31-32). Given the known in common reason for the visit, and the discussion up to this point, "take a look" is hearable as in reference to confirming the loss via visualization on the ultrasound.

SECONDARY ORIENTATION: FOR PATIENT'S BENEFIT

Patient-initiated introductions via mitigated requests

In three of the 18 initial ultrasound mentionings analyzed for this chapter, it is the patient who brings up the idea of performing an ultrasound, via request. This suggests that patients can and do regard the ultrasound as something they have a right to ask for. However, requests are notably mitigated in ways that register the contingencies entailed in granting the ultrasound (Curl and Drew 2008). Two of these requests are direct, and the third is indirect.

Direct request. In two of the cases analyzed in this study, the patient explicitly mentions the ultrasound first. In both cases, she formulates her utterance in the form of a direct request, as seen below in 010-01:

Excerpt 3.8

```
010-01 (27 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
US machine present, off
0:00  ((Pat (on table) and comp (off camera) chatting))
01 Doc:     Hey Miss Torres, thanks for comin' on in. ((entering room))
02 Pat:     Hi:,  ((looking to Doc entering reading chart))
03          (0.6)  ((Doc closing door behind her, reading chart))
04 Doc:     Um:, questions? Problems?
05          (0.7) ((Doc closes door, steps into room, looks to pt))
06 Pat:     Um::?
07          (0.5)  ((Doc moves to counter, reading, pt watches Doc))
08 Pat:     tch No problem:s, everything's been well,
```

```
09 Doc:     Oh good!
10 Pat:  -> Yeah, .hh Um:,  ((glances at US machine then back to Doc))
11       -> only had one question[:,(hn),
12 Doc:                          [Yes  mam.
13 Pat:  -> Ah: I don't know if you guys 'd- be willing to do
14       -> an ultrasound at all,  ((Doc glances to pt, back to chart))
15 Doc:     Sure I can do it. What would you like to:see on the
16          ultrasound.
17          (0.6)  ((Doc setting chart on counter))
18 Pat:     Ah: jus-
19          (.)  ((Doc moves to US machine))
20 Com:     The s[ex,]  ((off camera))
21 Pat:          [May]be the sex, if: I: [if  I  can handle] it.
22 Doc:                                  [Come take a peek.]
```

In this example, the consultation has just started. When the doctor solicits questions and concerns, the patient first states that she has no concerns. After the doctor positively assesses this fact, the patient then begins to formulate her request. As would be expected in an environment where she has low authority relative to her recipient, she minimizes her request heavily. First she begins with a pre-delicate (Schegloff 1980), announcing that she "only" has one question. As the doctor solicited questions or problems at the start of the visit, the announcement of a question is unnecessary, but the addition of "only" stresses a minimal burden to the doctor. Then, when the doctor gives the go-ahead ("Yes mam"), the patient states her request, beginning with an elongated "Ah," which displays hesitation. "I don't know if you guys [woul]d be willing" emphasizes her awareness of contingencies that may prevent the request from being granted (Curl and Drew 2008). By the time she gets to the heart of the request, "do an ultrasound," she has already displayed considerable deference to the doctor. She finishes her term with one last mitigating element, the negative polarity item "at all," which flips the polarity of the question from positive to negative, making it fitted to expect a negative response. Thus, though the patient does take the initiative to bring up the possibility of an ultrasound herself, she does so in a heavily mitigated way that defers to the doctor's authority to make the call, while also pushing for acceptance (Clayman and Heritage 2015). The doctor responds readily by granting the

request (“Sure I can do it,”) and the lack of hesitation or request for justification treats the request as having been valid and reasonable. In this way, the doctor agrees to a request to perform an ultrasound in the absence of any medical reason to do one.

028-01 also contains an explicit patient request.

Excerpt 3.9

```
028-01 (32 wks), no companion, return pt
pt seated on table, doc at counter
US machine present, on
2:51
01 Doc:     And do you have any questions about anything else?
02          Did you get a chance to talk with Carla?
03          (0.6) ((Doc still in chart))
04 Pat:     Uhm no I didn't.
05 Doc:     Okay,=
06 Pat:  -> =Bu:t, ((glances at US machine)) I was wondering if I
07       -> can get an ultrasound?=
08 Doc:     =Of course!
09          (1.2) ((Doc writing in chart))
10 Doc:     We'll go ahead and do that right now.
11 Pat:     °Okay,° ((looks down and away from doc and machine))
12          (0.8)
13 Doc:     An:d what about the breastfeeding class.=You missed
14          the breastfeeding class we had yesterday,
15          (0.2)
16 Pat:     .h I didn't know- (.) there was one,
```

This patient is already in her third trimester, and is the sister of one of the clinic’s medical assistants, possibly giving her a more thorough familiarity with the clinic and its visit protocol than patients without such a relationship would have. A few minutes into the consultation, the doctor and patient have already discussed hospitals for delivery, baby movement, and the patient’s weight gain. The doctor checks for further questions from the patient with a negative polarity question (both the “any questions” and “anything else” are negatively polarized), and instead of waiting for an answer, continues immediately on to ask if the patient had a chance to talk with the clinic nutritionist, Carla. After a half second pause, which allows the patient to switch gears between addressing the solicitation for further questions and addressing the direct question regarding speaking with Carla, the patient responds that she did not have a chance to

speak with Carla. She then moves quickly on with "But," indexing that what will follow is unexpected given what came before. Despite the doctor's negative polarity construction, she does in fact have an additional question. After a quick glance to the ultrasound machine (which the doctor does not see, as she is engaged with the chart), the patient begins her request with "I was wondering if", the classic low-entitlement, contingency-aware format common to medical settings (Curl and Drew 2008). Then, "I can get an ultrasound" de-emphasizes the doctor's burden of performing one while still indexing it as something she cannot do herself. Thus, although she demonstrates a right to ask for an ultrasound, she does so carefully, downplaying her entitlement. The doctor responds quickly with "Of course!", which suggests that the patient's deference was unnecessary, then states an intention to comply with the request right away. Despite the doctor's quick agreement, the patient does not offer much of a reaction to being granted an ultrasound, with a barely audible "okay" and gaze shift away from both the doctor and the machine.

Implicit request. Patient requests for ultrasounds are not always done explicitly. In 012-02, we see a patient wishing to learn the gender of her baby, but her pursuit of this clearly indicates she wants an ultrasound:

Excerpt 3.10

```
012-02 (20 wks), no companion, return pt
pt laying on table, doc at table with Doppler
US machine not present
10:40
01 Doc:     Little bit of pressure here,
02          (7.0)  ((listening for heartbeat))
03 Doc:     There is is,
04          (8.0)   ((continues listening))
05 Doc:     It moved,  ((moves Doppler))
06          (5.0)  ((continues listening))
07 Pat:     When will I be able to find out the: gender,
08          (1.0) ((Doc still listening to HB))
09 Doc:     I'll set you up for the anatomy scan.
10          (0.8) ((pt nods))
11 Doc:     And they can tell you. Probably within the next month.
12          (1.8)  ((still listening to doppler))
13 Pat:  -> °(I's not) possible: t'find out today,°
```

```
14 Doc:     Ah:: lemme see how many patients I am behind
15          and grab an ultrasound machine. O[kay]?
16 Pat:                                     °[Oka]y:.° ((whispered))
17          (1.0) ((Doc opens door and starts to walk out))
18 Pat:     °Thank you,° ((whispered))
19 Doc:     You're welcome I may not be able to tell, ((walking out))
```

The doctor first responds to the inquiry about gender with a plan to schedule the patient for an anatomy scan – high-resolution imaging that happens at another site, where sex is determined as part of standard routine (along with evaluation for certain birth defects that are visible via detailed imaging). She chooses not to offer this patient an ultrasound in clinic at this time, though that she responds in terms of an ultrasound done somewhere else suggests that she does interpret the patient's inquiry about gender as an ultrasound request. The patient presses to "find out today," but she does so in a highly mitigated way. Mumbling, she delivers a negative declarative question, built heavily for a no, registering contingency with "possible" (Curl and Drew 2008), and still not mentioning ultrasound by name. The doctor, however, now does respond in terms of ultrasound in clinic – but also makes plain the contingencies of having to do one (noting that she is already behind patients, and would have to leave room to get machine) and qualifies the idea by noting she still might not be able to tell the gender even if she does do one. Nonetheless, "let me…grab an ultrasound machine" suggests obliging the patient's wishes, and its emergence from a discussion of the patient's curiosity as to her baby's gender suggests that the doctor will be performing it to satisfy the patient's curiosity for a non-medical reason. When the patient subsequently responds with "Thank you," she confirms that the doctor's interpretation of her inquiry about gender was correct – it was the ultrasound she was after.[3]

[3] It is worth noting, however, that the doctor still reserves the right to pass on granting an ultrasound when there is evidence that the patient wants one. In one example from a visit where an ultrasound is *not* performed, a companion (the patient's mother) inquires when the patient will get her next ultrasound. This is at the end of the visit, after the doctor has initiated the exit phase with "come on out." Instead of treating the

Suggestion of patient agency in doctor-initiated formulations

As stressed earlier, the majority of ultrasounds performed (15 of the 18 in this sample) follow from the doctor introducing the idea. Every single time the doctor introduces the ultrasound, she employs formulations that embody relatively low authoritativeness (Stivers et al. 2018), suggesting the patient has agency in deciding whether or not to do one. Specifically, she uses an offer format in nine of the 15 cases, a proposal for joint activity in five, and a request in one. Although the doctor consistently uses formats that suggest a low degree of authoritativeness and a high degree of patient agency, most of them are still overshadowed either by medical relevance or evidence of the doctor's intent to perform one, regardless of the format she uses to introduce it.

Offer. In three of the nine offers, there does not appear to be any medical reason for doing one, nor does the doctor display any obvious intention to perform one prior to introducing it. In 005-01, we see an example of this kind of pure, unattached offer:

Excerpt 3.11

```
005-01 (24 wks), no companion, return pt
pt seated on table, doc at counter
US machine present, on
2:05
01 Doc:     What happened. You were so worried.
02          (0.6)
03 Pat:     Uh:m:- Yeah I don't know I guess a lot of talking,
04          so, yeah,  ((Doc smiling and nodding))
05          (0.7)  ((Doc smiling))
06 Doc:     That's wonderful.
07 Pat:     Yeah,
08 Doc:  -> Do you wanna see the baby?
09          (0.2)
10 Pat:     Yes.
11 Doc:     Okay.
```

question as a request, the doctor simply answers that the patient will be due for another ultrasound the next month and continues to close the visit.

```
12          (0.4) ((Doc puts pen down, moves to pt))
13 Doc:     Go ahead and lie back.
```

A couple minutes into this visit, the doctor and patient have already gone over previous testing results, a previous ultrasound that shows the patient's due date, and weight gain, none of which were problematic. Use of the Doppler device revealed a "nice" heartbeat (in the doctor's words). At the start of the transcript, they are discussing the patient's social situation at home, which has been improving. So far there is no apparent medical reason warranting an ultrasound. After the doctor positively assesses the patient's report of talking with her partner at home, she offers an ultrasound in line 8. The offer is done as unconnected to the previous discussion in the visit, and "see the baby" is both the reason for and the formulation of the ultrasound itself. In using "Do you [want to]," the doctor frames the decision of whether or not to do the ultrasound as entirely up to the patient – and purely a matter of her desire (the doctor could also want to "see the baby" herself, but she does not indicate that). This formulation also implies that the patient could decline if she wanted to. Its disconnect with the previous talk and emphasis on patient inclination suggest that whether or not to perform one is truly up to the patient, for her own curiosity.

In six of the nine times the doctor formulates an offer, she does so despite having already made relevant a medical justification for performing the ultrasound. For example, in 019-01, which we saw earlier, the doctor offers an ultrasound after confirming that the patient did not have one done at her previous clinic:

Excerpt 3.12

```
019-01 (17 wks), companion present, return pt
pt seated on table, comp in chair, doc seated at counter
US machine not present
4:40
01 Doc:     You can avoid this? Okay? .hh Let's listen to the
02          baby's heartbeat for a minute, did you get an
03          ultrasound during the pregnancy?
```

```
04 Pat:     Um: only one.
05 Doc:     Only one?
06          (0.6) ((Pt nods, doc in chart))
07 Doc:     °Okay.°
08          (2.4) ((Doc rises, sets chart on counter))
09 Doc:     Go ahead and lie back, let's listen to the heartbeat.
10 ((30 seconds — discuss movement, listen to heartbeat via Doppler))
11 ((Doc grabs paper towel and walks to table, wiping off Doppler))
12 Doc:     Did anyone check something called a hemoglobin A one C?
13          When you were (.) first pregnant?
14 Pat:     I don't think so, ((shakes head))
15 Doc:     You don't think [so.
16 Pat:                     [Oh:, well they did draw my blood.
17          An:d, but I don't think I: they had given me the-
18          uh: results [for  that]
19 Doc:  ->             [Did you w]ant a quick ultrasound today?
20 Pat:     Yes.  ((smiles))
21          (0.6) ((Doc moves light and pulls curtain to get to door))
22 Doc:     Hang on a second let me get the machine.
23 ((45 seconds — Doc exits, pt and friend react to HB while doc gone))
24 ((27 seconds — Doc enters with machine, preps it and pt silently))
25 Doc:     Let's take a ⇧peek, I'm gonna turn the lights off,
26          (0.6) ((Doc turning off lights))
27 Doc:     So when you said you only had one ultrasound during
28          the pregnancy, when was that one,
```

As noted earlier, the ultrasound is treated as justified by the fact that one had not yet been done at this clinic. Yet, the doctor chooses to formulate an in-clinic ultrasound as an offer in line 19, minimized to stress low inconvenience to the patient.

Proposal for joint activity. Like offers, proposals are usually (four of the five cases) produced by the doctor within the context of medical justification. We have seen this already in 001-03 and 021-01 above. Another example of this is found in 023-01:

Excerpt 3.13

023-01 (6 wks), no companion, new pt
pt on table, doctor performing pelvic exam
US machine present, on
6:02

```
01 Doc:     I think you can get- a totally normal sized baby
02          out, no problem.
03          (0.4)
04 Pat:     I see:, heh heh heh
05 Doc:     See if you decide.
06 Pat:     H[m,
07 Doc:  ->  [Okay. An:d, the uterus feels, about three months
08       -> so let's do a quick ultrasound and see,
09 Pat:     Okay,
10 Doc:     Go ahead and put your feet in the middle,
```

This patient is new to this clinic. They have been discussing a previous pregnancy in which the baby was so big, it had to be delivered via C-section. The doctor is actually performing a pelvic exam at the start of this excerpt, and is palpating the patient's vaginal canal. After noting that the patient should not have trouble with a "normal sized baby" in line 1, the doctor then moves her outside hand to the patient's belly to feel how big the uterus has gotten. She notes that it feels "about three months," (line 7) and then proposes a "quick ultrasound" to confirm this (interestingly, she will determine during the ultrasound that the fetus is only six weeks along). By the time she formulates the proposal, then, ultrasound has already been made medically relevant given the new patient status and concern for another possible large baby. (Also, "Let's" format indicates the disjuncture between the current activity and the new activity proposed (Stivers and Sidnell 2016). All four of the medically-justified proposals are produced in "Let's" format.)

In the remaining proposal case, although no medically relevant reason has been made obvious, the doctor proposes an ultrasound after she has already made it clear physically that she will perform one. In 006-02, she turns the ultrasound machine on and adjusts its position prior to delivering the proposal:

Excerpt 3.14

```
006-02 (11 wks), companion present, return pt
pt seated on table, comp in chair, doc standing at table
US machine present, off
3:52
01 Doc:     Are you having any discharge or any discomfort
02          when you're not having sex? ((Doc walks to US machine))
03 Pat:     Um: I did notice there's like-
04          (0.3) ((Doc reaches behind US machine))
05 Pat:     Som::e, it's like yellow when [I] get s:tressed out or
06 ***   ->                              [*] ((doc turns machine on))
07 Pat:     when I'm ru[nning around] a l-
08 Doc:                [  uh - huh, ]
09          (.)
10 Pat:     A lot at work?
11 Doc:  -> M-hm? ((Moves machine closer to table, turns to counter))
```

```
12 Pat:     Uhm,
13          (0.4) ((Pt looks down at hand, doc grabs paper towel))
14 Pat:     It's like yellowish. ((touches palm with L index finger))
15 Doc:     But nothing that smells bad and nothing that
16          itches?  ((hands pt paper towel))
17 Pat:     No.
18 Doc:     I think you're okay.
19 Pat:     Okay.  ((wiping off hand))
20 Doc:  -> How bout we take a look at the baby.
21 Pat:     Okay.  ((still wiping off hand))
22          (0.4)  ((Doc looks to companion off camera))
23 Doc:     'S'at why you're here?
24 Pat:     Ye:ah,
```

This excerpt starts toward the end of a discussion about discomfort during sex. (The doctor has placed a small amount of lubricant in the patient's right hand, which is still there at the start of this excerpt.) The doctor and patient have already discussed previous testing, nausea, the patient's weight, and a knee injury, with nothing concerning coming to light. As the doctor asks about discharge outside of sex in lines 1-2, she approaches the ultrasound machine and turns it on as the patient answers. She then adjusts the machine so it is closer to the exam table on which the patient is sitting. From this action it's pretty clear that she intends to perform an ultrasound. After confirming that the patient does not have any discharge that smells or itches, the doctor wraps up that discussion with a no-problem assessment: "I think you're okay", which the patient accepts with an "Okay" in line 19. By this time, the ultrasound machine has booted up and is ready for use. The doctor then delivers a proposal for ultrasound. "Take a look at the baby" is both the formulation of the ultrasound itself and the reason for doing one, as no medical reasons have made themselves apparent up to this point. The "How [a]bout we" that precedes it is a true proposal format, understood to be a proffering of an idea for action that can be agreed with or declined. Although the particular format used does not suggest disjuncture with the ongoing discussion, as one might expect (Stivers and Sidnell 2016), the doctor's act of turning the machine on makes her proposal conjunctive with her physical activity if not with the

discussion in progress. In this way, she has made it clear that an ultrasound will be happening (indeed, has already begun), despite using a format that suggests collaboration.

Doctor request. As seen earlier, in the one instance of doctor request for an ultrasound, the doctor both makes a medical justification relevant and interacts with the machine prior to making the offer:

Excerpt 3.15

```
026-01 (21 wks), no companion, new pt
pt seated on table, doc at US machine entering data
US machine present, on
0:30
01 Doc:     So were they able to do anything at Imperial
02          bloodwork er:: a pap test or anything like that?
03 Pat:     No pap, they did, uh: take some bloo:d, b'that
04          was about it,
05          (1.2) ((Doc at US machine, pt looks to doc))
06 Doc:     Okay and did they do an ultrasound?
07          (0.2) ((Doc steps back from machine))
08 Pat:     No I didn't get that far. ((shaking head))
09 Doc:     Y'didn't get that far.
10 Pat:     Mm, ((shaking head))
11 Doc:  -> So can we do an ultrasound real quick today to
12          get an idea as to how far along you are?
13 Pat:     Yes.
14 Doc:     Go ahead and lie back.
```

The doctor chooses to frame her ultrasound introduction in line 11 as a request ("can we do") that the patient can grant or deny – suggesting that the decision here lies with the patient, rather than the doctor. She even adds the mitigating phrase "real quick" to emphasize that it would not inconvenience the patient too much and push for acceptance (Clayman and Heritage 2015). But, as noted earlier, by the time the doctor asks to perform an ultrasound, she has already been interacting with the ultrasound machine, and has ascertained that this patient did not have an ultrasound performed during her previous care in another health system ("Imperial"). So both the justification for and the intention to do an ultrasound are already apparent, and had the patient chosen to deny the request, it would have been difficult work.

Thus, despite the doctor's consistent use of formats that suggest a low degree of authoritativeness and a high degree of patient agency, the majority of doctor-initiated ultrasound introductions are overshadowed by either medical reason, doctor intent, or both. Offers do sometimes appear to be used in their "pure" form, occurring absent of medical motivation, but overall, most offers and proposals and the doctor request come off as being performed in the doctor's interest.

Non-medical reasons: Gender, "see the baby," and patient desire

As demonstrated above, ultrasounds with medical justifications outnumber those without. But in the cases absent of a medical reason (seven of 18), nonmedical reasons are indexed, by both the doctor and the patients.

Gender. All three of the above patients who request an ultrasound do so because they are interested in learning the gender of the baby. In 012-02, the patient uses an inquiry about gender as an implicit request for the ultrasound. And in 010-01, which we have already seen, the doctor solicits the patient's reason immediately after granting the request:

Excerpt 3.16

010-01 (27 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
US machine present, off
0:00
01 Doc: Hey Miss Torres, thanks for comin' on in. ((entering room))
02 Pat: Hi:, ((looking to Doc entering reading chart))
03 (0.6) ((Doc closing door behind her, reading chart))
04 Doc: Um:, questions? Problems?
05 (0.7) ((Doc closes door, steps into room, looks to pt))
06 Pat: Um::?
07 (0.5) ((Doc moves to counter, reading, pt watches Doc))
08 Pat: tch No problem:s, everything's been well,
09 Doc: Oh good!
10 Pat: Yeah, .hh Um:, ((glances at US machine then back to Doc))
11 only had one question[:,(hn),
12 Doc: [Yes mam.
13 Pat: Ah: I don't know if you guys 'd- be willing to do
14 an ultrasound at all, ((Doc glances to pt, back to chart))
15 Doc: Sure I can do it. What would you like to:see on the

```
16          ultrasound.
17          (0.6)  ((Doc setting chart on counter))
18 Pat:  -> Ah: jus-
19          (.)  ((Doc moves to US machine))
20 Com:     The s[ex,]  ((off camera))
21 Pat:  ->      [May]be the sex, if: I: [if  I  can handle] it.
22 Doc:                                  [Come take a peek.]
23 Pat:     [Hhh!
24 Doc:     [I mean of the ultrasound you mean lying back?
25 Pat:     Mmm. ((smiling))
26          (0.2) ((Pt nodding, Doc pulls out footrest))
27 Doc:     >Go ahead and lie back.<
```

Immediately after granting the request, the doctor asks the patient what she would like to see. The patient starts to answer with "Ah: jus-", already downplaying the significance of her reason. After a cutoff and pause, her companion (her mother) completes her thought for her, and the patient comes in in overlap to give the same answer – "the sex." (The "maybe" and the "if I can handle it" are in reference to the patient's current inability to tolerate lying on her back for very long without feeling faint, which the doctor acknowledges in line 24.)

"See the baby." In the other patient request, 028-01, the patient again does not immediately give a reason for her request. In this case, the doctor solicits it after first talking about the breastfeeding class. The patient ends up giving two reasons – first, to see the baby, and then also to confirm the gender.

Excerpt 3.17

```
028-01 (32 wks), no companion, return pt
pt seated on table, doc at counter
US machine present, on
2:51
01 Doc:     And do you have any questions about anything else?
02          Did you get a chance to talk with Carla?
03          (0.6) ((Doc still in chart))
04 Pat:     Uhm no I didn't.
05 Doc:     Okay,=
06 Pat:     =Bu:t, ((glances at US machine)) I was wondering if I
07          can get an ultrasound?=
08 Doc:     =Of course!
09          (1.2) ((Doc writing in chart))
10 Doc:     We'll go ahead and do that right now.
11 Pat:     °Okay,° ((looks down and away from doc and machine))
12          (0.8)
13 Doc:     An:d what about the breastfeeding class.=You missed
14          the breastfeeding class we had yesterday,
```

```
15          (0.2)
16 Pat:     .h I didn't know- (.) there was one,
17 Doc:     Do you wanna do one next month? We have one coming
18          up next month,
19 Pat:     Yeah,
20          (0.6)
21 Doc:     Okay so the breastfeeding classes are usually in the
22          afternoon,
23 Pat:     Uh-h[uh,]
24 Doc:         [Uh:]make sure you sign up for it but you could
25          do the one: um next month at the same time as at
26          your regular visit? O[r,]
27 Pat:                          [Ok]ay,
28          (.)
29 Doc:     Different,
30          (0.8)
31 Pat:     M-hm,
32 Doc:     Go ahead and lie back. What do you wanna see on
33          the ultrasound.
34          (1.0) ((Pt moving and doc adjusting table))
35 Pat:  -> Uh:m I just wanna see the b-
36          (0.2) ((pt adjusting))
37 Pat:  -> Th-
38          (0.6) ((pt gesturing to US screen))
39 Pat:  -> Uh:m,
40          (0.6) ((pt turns forward again))
41 Pat:  -> The baby?
42 Doc:     Uh-ha[h?
43 Pat:  ->      [Just tuh- see-
44          (0.6) ((pt adjusting clothes))
45 Pat:  -> Confirm I guess, the-
46 Doc:     [Gender?]
47 Pat:  -> [Gender.] Yeah.
48 Doc:     Okay. And did you get the uh:m, appointment for
49          the anatomy scan, downtown?
```

When the doctor asks what she wants to see on the ultrasound, the patient answers, with considerable hesitation as she is repositioning herself lying down, that she just wants to "see the baby" (lines 35-41). Then, treating "see the baby" as insufficient by itself, she goes on, again with trouble, to add confirming the gender (having already learned the sex of the baby at a previous visit), which the doctor co-completes with her in line 47. Although the patient treats "see the baby" as insufficient, the doctor does not, responding to it with "Uh-huh?" in line 42. This plus her simple co-completion of "Gender?" followed by "Okay" and swift transition to asking about the anatomy scan show that she treats both "see the baby" and confirming gender as acceptable reasons for a patient to ask for an ultrasound.

Not only will the doctor accept "see the baby" from the patient as an adequate reason, she will also mention it herself, in absence of any medical reasons. When this happens, the doctor's introduction of the ultrasound is never connected to the previous discussion – it instead comes off as utterly out of the blue. There are three occurrances of this in the sample. Two of them, including 005-01, which we saw earlier, involve the doctor introducing the ultrasound with a version of the question "Do you want to see the baby?":

Excerpt 3.18

005-01 (24 wks), no companion, return pt
pt seated on table, doc at counter
US machine present, on
2:05

```
01 Doc:     What happened. You were so worried.
02          (0.6)
03 Pat:     Uh:m:- Yeah I don't know I guess a lot of talking,
04          so, yeah,  ((Doc smiling and nodding))
05          (0.7)  ((Doc smiling))
06 Doc:     That's wonderful.
07 Pat:     Yeah,
08 Doc:  -> Do you wanna see the baby?
09          (0.2)
10 Pat:     Yes.
11 Doc:     Okay.
12          (0.4) ((Doc puts pen down, moves to pt))
13 Doc:     Go ahead and lie back.
```

As noted earlier, "see the baby" is both the reason and the formulation of the ultrasound itself, as performing an ultrasound is understood to be the default mode by which a fetus can be "seen." In forming her utterance this way, the doctor suggests that merely seeing the baby is justification enough for performing an ultrasound. As nothing discussed previously has suggested that an ultrasound would be necessary, the offer is presented as unconnected to previous discussion, casually out of the blue, done for no other reason than to satisfy curiosity.

In the third doctor-imitated "see the baby" instance, which we have also seen previously, the doctor proposes "taking a look" at the baby to the patient and her companion, the baby's father:

Excerpt 3.19

006-02 (11 wks), companion present, return pt
pt seated on table, comp in chair, doc standing at table
US machine present, off
3:52

```
01 Doc:     Are you having any discharge or any discomfort
02          when you're not having sex? ((Doc walks to US machine))
03 Pat:     Um: I did notice there's like-
04          (0.3) ((Doc reaches behind US machine))
05 Pat:     Som::e, it's like yellow when [I] get s:tressed out or
06 ***                                    [*] ((doc turns machine on))
07 Pat:     when I'm ru[nning around] a l-
08 Doc:                [  uh - huh, ]
09          (.)
10 Pat:     A lot at work?
11 Doc:     M-hm? ((Moves machine closer to table, turns to counter))
12 Pat:     Uhm,
13          (0.4) ((Pt looks down at hand, doc grabs paper towel))
14 Pat:     It's like yellowish. ((touches palm with L index finger))
15 Doc:     But nothing that smells bad and nothing that
16          itches?  ((hands pt paper towel))
17 Pat:     No.
18 Doc:     I think you're okay.
19 Pat:     Okay.  ((wiping off hand))
20 Doc:  -> How bout we take a look at the baby.
21 Pat:     Okay.  ((still wiping off hand))
22          (0.4)  ((Doc looks to companion off camera))
23 Doc:     'S'at why you're here?
24 Pat:     Ye:ah,
25          (0.6)  ((Doc nods and looks to US machine))
26 Com:     [  M m  —  h m , ]
27 Pat:     [>He didn't get t]'see it< last time, so:,=
28 Doc:     =(W'l) it'll look like more this time.
```

Again, and similar to the above case, "take a look at the baby" is both the formulation of the ultrasound itself and the reason for doing one, as no medical reasons have made themselves apparent up to this point. After delivering the proposal, the doctor turns to the baby's father in line 22 and asks if "that" (meaning taking a look at the baby, meaning the ultrasound) was why he had come along to the visit. In asking that question, the doctor makes it very clear that "taking a look" is not only an acceptable reason to perform an ultrasound, it's also an acceptable justification for a companion to be present in the first place. Indeed, the presence of the partner might actually be what prompted the doctor to propose the ultrasound, as although the patient did have one at her previous visit, her partner "didn't get to see it" that time (line 27).

Patient desire. In one single case, no reason for doing an ultrasound is immediately evident at all. When this happens, the disconnect between introduction of the ultrasound and what has happened previously in the visit suggest a next-on-list nature of a procedure so taken for granted, it needs no justification whatsoever aside from the patient's implied interest. In 018-01, the doctor offers an ultrasound to the patient quickly on the heels of stating a plan to check the baby's heartbeat and drawing a birth defects blood test.

Excerpt 3.20

018-01 (11 wks), no companion, return pt
pt seated on table, doc at counter with chart
US machine present, not on
4:10

```
01 Doc:     So I'll give you some stuff to read,
02 Pat:     Mm:?
03 Doc:     And then let's take a listen to the heartbeat?
04 Pat:     Ohkay.
05 Doc:     An::d,
06          (0.8) ((Doc writing in chart))
07 Doc:     We're gonna draw the b- first blood test for birth
08          defects if that's ok[ay. (             )]((Doc to counter))
09 Pat:                          [Oka]y. And it's jus]t blood
10          testing right?
11 Doc:     It's just blood testing.  ((Doc sets chart, grabs Doppler))
12 Pat:     Okay. >Yeah [cuz my mom told me 's like-<]
13 Doc:  ->             [Did  you   (want  an)  ultra]sound?
14 Pat:     Um:, yeah I do want the ultrasound.
15 Doc:     O[kay.     ((Doc puts Doppler back down, moves to machine))
16 Pat:      [>But my mom had asked me she like yeah if it's gonna
17          be anything with a< needle like —cuz I had talked to her
```

This transcript begins about four minutes into the visit, during which the doctor has solicited questions and concerns from the patient and discussed birth control with her. After explaining in detail various birth control options, the doctor wraps up discussion of birth control methods with "So I'll give you some stuff to read," indicating that the patient can continue thinking about which birth control method to use after the baby is born on her own, after the visit. Next she delivers, in rapid succession, plans for the rest of this visit: listening to the heartbeat and drawing blood for the first of two birth defects tests. The patient agrees quickly to listening to the heartbeat, but after hearing plans for the "first blood test for birth defects", the

patient asks for confirmation that this test will be "just blood testing," (presumably as opposed to amniocentesis, a more invasive test which involves collecting fluid from the amniotic sac). The doctor confirms the patient's impression, repeating her phrasing word for word. The doctor, having set down the chart, then picks up the Doppler device and starts to shift her weight toward the patient. But once the patient confirms understanding with "Okay," the doctor continues then asks the patient if she wants an ultrasound, seemingly out of the blue, and cutting off the patient, who has begun an account for why she had asked for clarification regarding the testing. Despite the doctor's formulation of the ultrasound via an offer (which the patient, in theory, could decline), the unadorned presentation of the ultrasound, unconnected to previous discussion and following so closely after introduction of listening for the heartbeat and drawing blood, makes the ultrasound hearable as a next-on-list procedure, taken for granted as a regular part of the prenatal visit, thereby needing no justification. As soon as the patient confirms that she does want one, the doctor sets the Doppler device back down and moves to turn on the ultrasound machine, suggesting that her offer of an ultrasound was actually intended to stand in place of the Doppler, as an ultrasound can also detect fetal heartbeat (more precisely than a Doppler at this early stage). However, that reasoning is not evident until the doctor sets the Doppler back down – in her delivery of the offer, she introduces the idea out of the blue. The patient takes a short moment to process the offer with "Um:" but then readily agrees, mirroring the doctor's phrasing for emphasis "I do want the ultrasound." Having confirmed desire for an ultrasound, she then immediately shifts focus back to her account for asking for clarification about the birth defects test. In this way, the ultrasound is proffered and agreed to quickly and without immediate justification.

USING THE SECONDARY ORIENTATION TO MASK CONCERN

In examining these cases, we have seen that the doctor overwhelmingly brings up the ultrasound, usually in the context of medical relevance. But, she can also invoke the ultrasound in contexts when the only thing at stake appears to be the patient's curiosity, and she always uses formats that suggest a high degree of patient agency. Also, patients can and do initiate requests for ultrasounds themselves, and the doctor treats these requests as appropriate, confirming that ultrasound is something that patients have a right to ask for – for nonmedical reasons. Yet, patient requests are heavily mitigated, showing considerable deference to the doctor's authority, and in general medical reasons do outnumber nonmedical reasons for performing an ultrasound, despite the doctor's use of patient-friendly formats. And in some cases, the doctor begins engaging with the ultrasound machine, showing intent to perform an ultrasound, before it is even mentioned. Although evidence for both a medical orientation and an orientation towards satisfying patient's curiosity exist (often in within the same case), the primary orientation still appears to be that of the ultrasound as a medical tool, the use (or non-use) of which is determined by the doctor. Why, then, would the doctor and patient maintain a secondary orientation of the ultrasound as something done for fun?

Looking beyond the initial mentioning of the ultrasound reveals some evidence that the secondary orientation of ultrasounds as for the patient's benefit can actually be used to mask medical justifications that aren't voiced initially. Both the doctor and the patient may have concerns that they choose not to emphasize when bringing up the ultrasound, which come out later in discussion.

In 010-01, described earlier, the doctor grants the patient's request to perform an ultrasound to find out the sex of the baby. However, once the ultrasound starts, she asks to measure the size of the baby before looking to see what the sex is.

Excerpt 3.21

010-01 (27 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
US machine present, off
0:00

```
01 Doc:     Hey Miss Torres, thanks for comin' on in. ((entering room))
02 Pat:     Hi:,  ((looking to Doc entering reading chart))
03          (0.6)  ((Doc closing door behind her, reading chart))
04 Doc:     Um:, questions? Problems?
05          (0.7) ((Doc closes door, steps into room, looks to pt))
06 Pat:     Um::?
07          (0.5)  ((Doc moves to counter, reading, pt watches Doc))
08 Pat:     tch No problem:s, everything's been well,
09 Doc:     Oh good!
10 Pat:     Yeah, .hh Um:,  ((glances at US machine then back to Doc))
11          only had one question[:,(hn),
12 Doc:                          [Yes  mam.
13 Pat:     Ah: I don't know if you guys 'd- be willing to do
14          an ultrasound at all,  ((Doc glances to pt, back to chart))
15 Doc:  -> Sure I can do it. What would you like to:see on the
16       -> ultrasound.
17          (0.6)  ((Doc setting chart on counter))
18 Pat:     Ah: jus-
19          (.)  ((Doc moves to US machine))
20 Com:     The s[ex,]  ((off camera))
21 Pat:          [May]be the sex, if: I: [if  I  can handle] it.
22 Doc:                                  [Come take a peek.]
23 Pat:     [Hhh!
24 Doc:     [I mean of the ultrasound you mean lying back?
25 Pat:     Mmm. ((smiling))
26          (0.2) ((Pt nodding, Doc pulls out footrest))
27 Doc:     >Go ahead and lie back.< Cuz I thought we weren't gonna
28          see you till the breastfeeding class next week.
29 Pat:     Right,
30 ((33 seconds — Discussing BF class while preparing for US))
31 ((Doc begins US))
32 Doc:     Okay, so let's look, ((turns screen toward pt))
33          (0.6)
34 Doc:     Here's the baby's head,  ((points to screen with L hand))
35 Pat:     'Kay,
36 ((10 seconds — Head, heartbeat, movement; comp rises to see))
37 Com:     Amazing,
38          (0.8)   ((Doc repositions wand))
39 Doc:  -> So: I don't- (0.8) Let's- (.) do a quick ultrasound fer:
40          size, is that okay?
41 Pat:     M-hm,
```

As we saw earlier, the doctor agrees to the patient's request for an ultrasound, and inquires as to the patient's reason as she is setting up the machine. The doctor offers no reason of her own for wanting to do one, so as the ultrasound begins, it appears to be done solely because the patient requested it. However, about ten seconds in to the ultrasound, after noting the shape of the head as well as heartbeat and movement, the doctor repositions the wand and starts to say "So I don't" but then cuts herself off. (This is likely the beginning of an account for why she cannot determine the sex of the baby, which she will explain later.) After a pause, she changes gears with a new proposal, "Let's do a quick ultrasound for size, is that okay?" Formatted to note a change of action (Stivers and Sidnell 2016), this proposal reveals a medically relevant reason for doing the ultrasound that the doctor did not bring up before on her own or mention when granting the patient's request. If the doctor was thinking of checking for size (and it's likely she was, as this patient's due date is questionable because she did not come for her initial visit until relatively late), she allowed the patient's request to do an ultrasound to find out the sex to serve as the motivation for doing one.

It is not only the doctor who might mask medical concerns with nonmedical reasons. Looking ahead in 028-01, the patient's wish to confirm the sex of the fetus is called into question when, at the end of the ultrasound, she asks if her baby is "normal":

Excerpt 3.22

028-01 (32 wks), no companion, return pt
pt seated on table, doc at counter
US machine present, on
2:51

```
 01 Doc:     And do you have any questions about anything else?
 02          Did you get a chance to talk with Carla?
 03          (0.6) ((Doc still in chart))
 04 Pat:     Uhm no I didn't.
 05 Doc:     Okay,=
 06 Pat:     =Bu:t, ((glances at US machine)) I was wondering if I
 07          can get an ultrasound?=
 08 Doc:     =Of course!
 09          (1.2) ((Doc writing in chart))
 10 Doc:     We'll go ahead and do that right now.
```

Pat: °Okay,° ((looks down and away from doc and machine))
(0.8)
Doc: An:d what about the breastfeeding class.=You missed
the breastfeeding class we had yesterday,
(0.2)
Pat: .h I didn't know- (.) there was one,
Doc: Do you wanna do one next month? We have one coming
up next month,
Pat: Yeah,
(0.6)
Doc: Okay so the breastfeeding classes are usually in the
afternoon,
Pat: Uh-h[uh,]
Doc: [Uh:]make sure you sign up for it but you could
do the one: um next month at the same time as at
your regular visit? O[r,]
Pat: [Ok]ay,
(.)
Doc: Different,
(0.8)
Pat: M-hm,
Doc: Go ahead and lie back. What do you wanna see on
the ultrasound.
(1.0) ((Pt moving and doc adjusting table))
Pat: Uh:m I just wanna see the b-
(0.2) ((pt adjusting))
Pat: Th-
(0.6) ((pt gesturing to US screen))
Pat: Uh:m,
(0.6) ((pt turns forward again))
Pat: The baby?
Doc: Uh-ha[h?
Pat: [Just tuh- see-
(0.6) ((pt adjusting clothes))
Pat: Confirm I guess, the-
Doc: [Gender?]
Pat: [Gender.] Yeah.
Doc: Okay. And did you get the uh:m, appointment for
the anatomy scan, downtown?
((40 senconds — Discuss anatomy scan, Doc measures belly))
Doc: And that means you've grown three and half centimeters
in four weeks,
(0.6) ((Doc walking to US machine))
Doc: °Very good.°
(1.0) ((Doc moves to machine, grabs gel))
Doc: And let's take a look at the baby, 4:37
((55 seconds, US start, head, heartbeat, pt minimal response))
Doc: You're concerned about gender?
Pat: Y(h)eah a little bit,
Doc: Why?
(0.6)
Doc: What- what is worrying you about gender. ((Wand off))
(0.6)
Doc: It [is one or] the other,
Pat: [I jus: ()]
Pat: Yeah(h)(h)!
(0.8) ((Doc puts more jelly on wand))
Doc: Have you bought a bunch of junk? ((Wand back to belly))

```
 69 Pat:     No: not really,
 70 Doc:     You don't need to actually buy anything except diapers.
 71          Which are gender neutral last time I looked,
 72 Pat:     eh-heh!
 73          (0.4)
 74 Doc:     Okay.=So: see this: big scrotum,
 75 Pat:     Uh-huh,
 76          (1.4)
 77 Doc:     An::d there's the: (.) testicles and a penis.
 78          (0.6)
 79 Pat:     nhh!
 80 Doc:     Is that what they told you before?
 81 Pat:     Yeah.
 82 Doc:     It's definitely a boy.
 83 Pat:     eh-heh!
 84 Doc:     Can you- can you see: those eh::, that- cir[cular,
 85 Pat:                                                [Yeah,
 86          (1.2)
 87 Pat:     [I  see  it,]
 88 Doc:     [Try to get,] there. ((moving wand))
 89 Pat:     (                  )
 90          (1.8)  ((Doc clicks on machine, points to screen))
 91 Doc:     Cirlces here,
 92 Pat:     Yeah,
 93 Doc:     And a little penis there,
 94 Pat:     eh-heh-heh!
 95 Doc:     So it is for sure a boy, for sure for sure,
 96 Pat:     Okay.
 97 Doc:     Fluid around the baby looks normal? See all the
 98          water there the black is the water,
 99 Pat:     °Mm-hm::,°
100 Doc:     An:d baby's head down?
101          (2.0)
102 Doc:     An::d you're feeling good movement  ((Doc removes wand))
103          and the si[ze is ex]actly=
104 Pat:               [Y e a h,]
105 Doc:     =as it should be? So that's all good!
106 Pat:     °M-hm,°
107          (0.4) ((Doc switches on light, moves to paper towel;))
108 Pat:  -> °Everything normal?°
109 Doc      .hh As near as we can tell,
110          (0.4)
111 Doc:     Go ahead and wipe off your belly.
112 Pat:     °Thank you,°
113 Doc:     Again the most important thing is for you not to
114          gain any more weight,
115 Pat:     Yeah,
```

This patient's request to have an ultrasound to "confirm" the gender is a bit odd, given that the sex of the baby had already been determined via ultrasound at a previous visit. The doctor inquires why the patient is "worried" about the sex in line 62, and the patient doesn't really have an answer. The doctor then clearly and deliberately points out the male sex organs in

lines 74-93, confirming that it is “for sure for sure” a boy. Perhaps wondering if the patient was worried about something other than the sex, the doctor reiterates that the patient is feeling “good movement” and notes that the size of the baby is “exactly what it should be,” and then adds to these positive assessments a final, emphatic general reassurance, “So that’s all good!” The patient acknowledges this with a quiet “m-hm,” and then after a pause, softly adds, “Everything normal?” Despite all the points of reassurance the doctor has just given her, she solicits a blanket reassurance to confirm that “everything” is as it should be. Looking back at her request and subsequent trouble locating “confirming the gender” as her reason, it becomes clear at the conclusion of the ultrasound that the patient was actually worried about “everything” being normal, but leaned on curiosity over the sex of the baby as her reason for requesting the ultrasound, rather than betray her concern.

DISCUSSION

Analyses of ultrasound introductions in visits where ultrasounds occur reveals a blending of a secondary orientation towards ultrasounds as done for the patient’s benefit mixed in with a primary orientation towards the ultrasound as a medical tool. Evidence of both orientations exist, often within the same case, but the predominance of medical reasons indexed for doing one, combined with the clear deference patients display to the doctor’s deontic authority in deciding whether or not to do one (even when they ask for one), demonstrate that both parties treat the ultrasound as primarily a medical tool.

And yet, there are cases where no medical reason surfaces, and the ultrasound appears to be done purely to satisfy the patient’s curiosity. These cases do not happen often, but the fact that they happen at all suggests a greater role for patient interests than what is officially recognized

by ACOG in determining when to perform one. It is perhaps unsurprising, then, that so many pregnant women wind up with more than the "at least one" indicated by the profession.

But why would the doctor bother taking the extra time to do one where it is not medically warranted? As we have seen, in some cases the "for fun" orientation is used to mask what turn out to be legitimate medical concerns that surface later, during the exam. But masking does not account for all of the ultrasounds that appear to be done to satisfy patient curiosity. Perhaps the reason for this doctor's willingness to perform more ultasounds than are medically warranted lies in her explanation of the purpose of prenatal care – to inform and screen. Although it does increase the total visit time relative to not doing one, performing a "quick" ultrasound (as she often describes them, suggesting minimal disruption to her routine) may be an ideal way for her to provide information to the patient – visual proof that her baby is fine – which acts as reassurance, while also giving herself an additional opportunity to take advantage of the "invaluable third eye" (Edvardsson et al. 2014) and confirm an apparently no-problem pregnancy, all the while presenting the act as satisfying the patient's wishes. In granting ultrasounds for apparently non-medical purposes, this doctor may be taking the patient's need for reassurance into account, and giving it some weight in her determination of how to conduct the visit.

Chapter 4. Shaping Future Courses of Action

Prenatal care contains many points of decision for the patient, and this chapter focuses on three of them. Here I will compare the initiation of three areas of yes/no choices of whether the patient will take a particular action or not: 1) attend a breastfeeding class, 2) use birth control after the baby is born, and 3) receive the whooping cough vaccine during pregnancy. The medical profession agrees that each of these is a good thing to do, but doctors cannot make them mandatory. The actual decisions are generally not captured in this dataset, as I typically only have one visit for each of the patients, and these discussions often do not warrant immediate decisions. Some of them have come up before in previous visits, and some will be discussed further at later visits before a definitive decision is reached. Previous discussion may or may not be evident in how they are introduced in these cases.

Whether the item is being broached for the first time or for a subsequent time, the doctor can steer the patient to varying degrees toward future courses of action by granting her more or less agency to decide. The patient can also index varying degrees of acquiescence in her responses. In this way, these discussions share features with those analyzed in other clinical settings. Similar to the treatment recommendations analyzed by Stivers et al (Stivers et al. 2018), the doctor formulates the introduction of the decision point in more or less authoritative ways. She commonly employs patient view elicitors like those identified by Chappel et al (Chappell, Toerien, Jackson, and Reuber 2018), and uses pre-recommendation techniques (Barnes 2018) to produce recommendations fitted to the patient's particular circumstances. All of these aspects combine to produce first actions that vary in the amount of deontic authority (the right to decide on action) (Stevanovic and Peräkylä 2012).

The extent to which the ultimate decision is treated as up to the patient appears to depend on what type of decision is being made. In the case of the breastfeeding class, the doctor generally recommends it, but her methods index a low authoritativeness, and decision is generally left up to the patient. This is especially true among experienced mothers; new mothers may experience more pressure to agree to the class. Use of birth control, by sharp contrast, is almost never up for discussion, and both the doctor and the patients display an expectation of its use after delivery. Pertussis seems to fall somewhere in between – at times it is presented as optional, at other times less so – although here again patient experience appears to play a role, with experienced moms experiencing more initial pressure to agree to the vaccine. In the discussion, I will consider various biomedical and sociocultural factors that may account for the varying levels of pressure and expectation seen in these cases.

For the data in this chapter, transcript excerpts will be labeled as followed:

Line 1: Visit # (weeks gestation), if companion present, new or return patient
Line 2: Physical orientation of individuals in room at start of transcript
Line 3: Gravidity (# pregnancies, including this one) and Parity (# births experienced)
Line 4: Time elapsed in visit at start of transcript

Example:

```
024-01 (32 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
Gravida 3, Para 1
0:52
```

UP TO THE PATIENT: BREASTFEEDING CLASS

The American Academy of Pediatrics (AAP) recommends that mothers breastfeed their babies exclusively for the first six months to maximize nutritional and immunologic benefits to the baby (American Academy of Pediatrics 2009). Breastfeeding provides benefits to the mother as well, including quicker recovery from childbirth, delayed resumption of menstruation (which can prevent new pregnancies from happening too quickly), and reduced risk of a variety of

conditions, including breast and ovarian cancer, type 2 diabetes, and cardiovascular disease (American Academy of Pediatrics 2011).

Roughly three fourths of American mothers breastfeed after birth, but rates fall to around half by six months and under a quarter by the time the baby is one year old (American Academy of Pediatrics 2011). Approximately one third of mothers who intend to breastfeed end up not breastfeeding at all (Perrine, Scanlon, Li, Odom, and Grummer-Strawn 2012). Reasons for not breastfeeding are not limited to physical factors of mom or baby – institutional and social factors play a role as well. Research suggests that targeting breastfeeding initiatives to new moms lacking social support may improve rates among lower income, less educated mothers (Persad and Mensinger 2008), and maternal education and breastfeeding knowledge helps moms achieve their breastfeeding goals (Chezem, Friesen, and Boettcher 2003).

The clinic at which the study doctor practices offers breastfeeding classes to any patient who wishes to take them. Classes are offered on a cyclical basis, and women enroll according to when they are due to receive instruction just before the baby arrives. On the whole, the decision of whether or not to attend a breastfeeding class is left up to the patient. Analysis of consultations reveals that the doctor generally uses less authoritative offer formats to introduce the class[4], commonly soliciting interest or displaying understanding of the patient's existing inclination, although there is some evidence that she places more pressure on new moms, who would not have had experience with breastfeeding before.

[4] For this chapter, I analyze mentionings of the breastfeeding *class* rather than breastfeeding itself because mentions of the class are more frequent. The doctor mentions breastfeeding by itself in only 4 of the 30 visits in my collection, whereas she mentions the class in 8 of the visits (and the 4 visits that include references to breastfeeding itself also include references to the class, as I will highlight below).

Five of the eight breastfeeding class cases occur with moms who have given birth before. One of the cases, 027-01, the doctor adds an offer after a solicitation of intent that gets no response:

Excerpt 4.1

027-01 (25 wks), no companion, return patient
Patient seated on table, doctor on stool with chart
Gravida 2, Para 1
9:55

```
01 Doc:     And then did you need information on the IUDs?
02 Pat:     Uh:m oh no I meant to look it up online, I haven't,
03          yet, uhm:,
04          (0.6) ((Doc looking at patient, patient adjusting clothes))
05 Pat:     So I'll look into that.
06          (0.4)  ((Doc looking at patient))
07 Pat:     I think um:,
08          (0.6)
09 Doc:  -> And what about breastfeeding.
10          (0.3)
11 Doc:  -> .h Ah we have some breastfeeding classes coming up,
12       -> would you like to do any of that?
13 Pat:     .hh I think I will wait? I did end up taking
14          breastfeeding classes last time >after I had my daughter<
```

After a discussion of birth control options, the patient declines the doctor's offer of information on IUDs, stating an intention to read into them online. Although the matter could be considered closed after the patient's turn in line 3, the doctor does not move forward, and the patient fills the silence with a sequence-closing statement of planned action at line 5. The doctor still does not begin a new topic, so the patient continues at line 7 with "I think um:" but does not finish her turn. After a pause, the doctor finally moves on with "And what about breastfeeding." With no uptake from the patient (line 10), the doctor continues with an offer for the breastfeeding class specifically. She informs the patient that "we" have "some breastfeeding classes coming up," then asks about the patient's interest with "would you like to do any of that," built for a no with negative polarity item "any." This question displays both low epistemic stance with its use of interrogative, and low deontic stance in leaving it up to the patient. The patient

responds by deferring declaring interest or disinterest – she will wait (line 13), because she already took a breastfeeding class after her last pregnancy (lines 13-14).

With experienced patients, the doctor may also rely on a third party for justification for bringing up the breastfeeding class, as we see in 008-01:

Excerpt 4.2

```
008-01 (30 wks), no companion, return patient
Patient laying on table, Doc at table with Doppler
Gravida 4, Para 2
2:32
01 Doc:     Baby sounds great!
02 Pat:     °Okay,°
03          (0.8)
04 Doc:     Hear?
05 Pat:     M-hm,
06          (16.0) ((MA finishing up blood draw, Doc to counter))
07 Doc:  -> And I have a note here: to offer you the
08       -> breastfeeding class,
09 Pat:     O[kay]:,
10 Doc:      [We-] .h Would you wanna do our breastfeeding
11          class?=[We have on]e coming up next week,
12 Pat:            [n Y e a h.]
13 Pat:     Yeah.
```

Wrapping up the heartbeat detection via Doppler, the doctor positively assesses the heartbeat and then moves to the counter and the chart. After a lengthy pause while she cleans up the Doppler device and looks in the chart, the doctor introduces the breastfeeding class. She starts by citing "a note here," meaning a notation in the chart written by whomever saw her last (likely the nurse midwife), thus positioning herself as not responsible for the idea she is about to impart (dubious since, as the only MD in the clinic, she has the most medical knowledge of all the staff). Congruent to the previous example, she continues by announcing what the note instructs her to do, "to offer you the breastfeeding class." The patient already responds with a fairly amenable stressed "Okay" in line 9, but the doctor continues by delivering the offer she has just announced in lines 10-11. She adds without pausing that there is one available next week, making it more appealing. This proves unnecessary as the patient is clearly interested,

coming in with “Yeah” in overlap after the offer, and repeating the “Yeah” in the clear with period intonation in line 13.

Twice, the doctor refers to the patient’s past experience with breastfeeding before offering the class, putting the patient in an easy position to decline taking a class this time around. In 009-01, she elicits the patient’s report of breastfeeding with her previous child:

Excerpt 4.3

```
009-01 (27 wks), no companion, return patient
Patient laying on table, Doc at table prepping Doppler with gel
Gravida 3, Para 1
3:54
01 Doc:     And that’s three centimeters more than four
02          weeks ago let’s listen to the heartbeat, and what time
03          are we drawing your blood.
04 Pat:     At eleven, ((Doc prepping Doppler, moves to table))
05 Doc:     Okay, we’ll getcha outta here in time.
06          (2.4)  ((Doc putting gel on Doppler))
07 Doc:  -> .hh Remind me did you breastfeed your first one?
08 Pat:     I did, for a couple months.
09 Doc:  -> Okay. Do you wanna go to breastfeeding class this time?
10 Pat:     Oh-ah: no,
11 Doc:     No?
12          (6.0) ((faint Doppler noises, doc moves it around))
13 Doc:     Somewhere here,
```

While preparing to listen for fetal heartbeat, the doctor asks the patient to “remind her” if she breastfed her first baby. After the patient answers in the affirmative with a qualification that it was “for a couple months” in line 8, the doctor registers with a shift-implicative period-intoned “Okay” in line 9, then adds an offer for the class. Having asked about the patient’s previous experience serves as a pre to the offer (Barnes 2018), establishing that this class may be superfluous. Adding “this time” implies that she did not go to class last time, which might be a reason to go, especially since the patient only breastfed her first baby for “a couple months.” Nonetheless, the patient declines (even registering the question as inappropriate with an “oh”-preface) in line 10. The doctor confirms the patient’s response in line 11, receives no uptake, and moves on.

In 004-01, the patient is currently breastfeeding, as her most recent child is still quite small. The doctor is aware of this and registers it before offering the class:

Excerpt 4.4

004-01 (29 wks), no companion, return patient
Patient laying on table, Doctor at counter with chart
Gravida 3, Para 2
5:23

```
01 Doc:     So based on your insurance:,
02          (0.4)    ((Doc at chart on counter))
03 Doc:     Um yes you can go to California.
04 Pat:     nn California,
05          (0.8)
06 Pat:     Or any ER when it's time right?
07 Doc:     [Any  E R   i[f you're stuck with] [(any odd) place,]
08 Pat:     [heh heh heh [    . h h h h      ] [   Y e : : a h  ]=
09          =eh: heh heh
10 Doc:  -> And I know you don't need a breastfeeding class
11       -> cause you've been breas[tfeeding,]
12 Pat:                            [ Ye:ah  I]'ve been
13          °breast[feed]in[g,°  ((Doc helping patient sit up))
14 Doc:  ->        [But-]  [we do offer a breastfeeding class
15       -> if you'd like one.
16 Pat:     M-hm, ((very high pitched))
17 Doc:     Y[ou'd like] to come to breastfeeding class?
18 Pat:      [M a w : ,]
19          (0.2)  ((Patient coming down from the table))
20 Pat:     I think I'm okay,
21 Doc:     °Okay,° .h So come on out thank you for your patience
22          with us today,
```

At the start of this excerpt, the doctor has completed all the usual business of the visit (including measuring and checking fetal heartbeat). After a quick discussion of which hospital to deliver at, prompted by a question from the patient, the doc notes that the patient does not need a breastfeeding class, since she is currently breastfeeding (line 10-11). Her "I know" plus negative declarative statement "you don't need a breastfeeding class" plus reiteration of evidence "because you've been breastfeeding" demonstrate high epistemic certainty, in addition to indexing the competence of the patient and her lack of necessity for the class. The patient confirms that she doesn't need the class with "Yeah" and the doctor's reasoning with "I've been breastfeeding" in lines 10-11. Nevertheless – and indexing the unexpectedness with "But-" in line 14, the doctor goes on to inform the patient that they offer the class anyway in lines 14-15,

and adds “if you’d like one” to stress that it’s merely a matter of patient interest. The patient provides a simple account for declining the offer, implying that she doesn’t need the class in line 20, and the doctor quickly moves to closing the visit.

One case of a breastfeeding class introduction occurs after the doctor has ascertained both the patient’s intent to breastfeed and her previous difficulty in breastfeeding her last child:

Excerpt 4.5

```
016-01 (37 wks), companion present, return patient
Patient seated on table, companion in chair, Doc at counter with chart
Gravida 2, Para 1
4:09
01 Doc:     So make sure you tell them that you rea:lly wanna
02          work on the breastfeeding and have them help you with
03          that because sometimes .hh it’s too easy for the nurses,
04          to jus:t >put a bottle in the baby’s mouth.<
05 Pat:     Okay.
06 Doc:  -> Um we have a breastfeeding class?=Here, have you had
07       -> a chance to do our breastfeeding cla[ss?
08 Pat:                                         [Um no I did that-
09          I did one at the WIC, hh cuz I go- I get WIC [and
10 Doc:  ->                                             [Would you
11       -> like to another one here as well I think we have one
12       -> coming up next week,
13 Pat:     No I think that would be fine I think if I need anything
14          I’ll just go back to the WIC.
15 Doc:     Okay,  ((to chart))
```

After stressing that the patient should instruct the staff at the hospital she chooses to deliver at to help her start breastfeeding, the doctor introduces the idea of the class in line 6. Emphasis on the word “class” implies dedicated careful instruction, which perhaps the patient would not find in the hospital in the post-birth recovery period, and adding “here” immediately after stresses the convenience to the patient. The doctor then asks if the patient has had a chance to do their class, hearably a pre on the way to offering it. The patient responds in the negative but then adds that she did do a class “at the WIC” (Women, Infants, and Children, a federal nutritional supplemental program). Still, the doc offers the class anyway in lines 10-12, indexing that it would be additional with “as well,” and noting how quickly it would start (“next week”).

The patient declines, again citing WIC as the reason she doesn't need the class at this clinic (lines 13-14).

With new moms, however, we do not see reference to the patient's past experience, as they by definition do not have any. Out of the three cases involving new moms, only one appears similar to the offers seen above. In 026-01, the doctor solicits the patient's intent to breastfeed, and then offers the class:

Excerpt 4.6

```
026-01 (21 wks), no companion, new pt
Pt seated on table, Doc leaning on counter facing pt
13:22
01 Doc:     You have good energy, you think you can still
02          exercise?
03          (0.3)
04 Pat:     tch Yeah: um: I actually don't live too far from
05          here so I walked here.
06 Doc:     Oh wonderful!
07 Pat:     Yeah,
08 Doc:     .h[h Uh]-
09 Pat:       [So:,]
10 Doc   -> Are you planning on breastfeeding.
11          (0.4)
12 Pat:     Yes.
13 Doc:     tch Can I take a quick peek at your nipples.=Just-
14          pull up,
15          (1.0)
16 Pat:     Wul i's- i's- ((it's it's)) (.) been kinda weird
17          cause like this one seems a little bit bigger
18          than this one?
19 Doc:     M-h[m?
20 Pat:        [So is that- tha[t's normal?
21 Doc:                        [Normal.
22 Pat:     Okay.
23 Doc:     And you've had a breast biopsy or something before?
24 ((20 seconds — cooking incident, scar on chest))
25 Doc:     You should be fine with breastfeeding. ((nod))
26 Pat:     Okay,
27 Doc:  -> We do have breastfeeding classes, a little bit later
28       -> in the pregnancy, you may wanna do one?They're about
29       -> an hour and half and usually in the afternoons.
30 Pat:     Okay, ((nods))
```

Similar to the cases we saw with experienced mothers, the doctor solicits the patient's intent to breastfeed in line 10. After the patient answers in the affirmative, the doctor quickly checks the patient's nipples (lines 13-21) and asks about a scar she sees. Declaring that the

patient "should be fine" with breastfeeding in line 25, the doctor then announces the class in lines 27-30, suggesting the patient "may wanna do one" later in the pregnancy, and explaining the length and timing. When compared to previous offers, however, the declarative format used here more strongly suggests agreement, and description of class details may presume interest in the class. The patient displays ready amenability to the idea in line 31.

In the other two new mom cases, the doctor puts even more pressure on the patient to participate in the class when introducing it. In 015-01, the doctor introduces the class and then presupposes the patient's participation:

Excerpt 4.7

```
015-01 (23 wks), companion present, return patient
Patient seated on table, companion in chair, Doc at counter with chart
Gravida 1, Para 0
10:08
01 Doc:     So we'll repeat that when you come back in next
02          time. Is that ar[right?]
03 Pat:                     [Okay, ] yeah,
04 Doc:  -> And then:, um we have: a breastfeeding class
05       -> every month, do you wanna do it this month?
06       -> (well/wow) I think it's on Monday or do you wanna
07       -> wait till the next month when you're a little
08       -> bi[t closer.]
09 Pat:        [Is:    is] it this Monday?
```

At the close of the visit, the doctor informs the patient that, at her next visit, the blood glucose test will be repeated. Then, she introduces the breastfeeding class. She announces its existence in lines 4-5, then adds what appears to be an offer, but with its emphasis on "this" rather than "do," actually presupposes the patient's participation (Chappell, Toerien, Jackson, and Reuber 2018; Toerien, Reuber, Shaw, and Duncan 2018). The patient responds with clarifying the timing, on her way to readily agreeing to do the class.

Finally, in 028-01, the doctor puts even more pressure on the patient, framing the class as a thing the patient should already know about and perhaps already be participating in:

Excerpt 4.8

```
028-01 (32 wks), no companion, return pt
```

```
Pat seated on table, Doc at counter
Gravida 1, Para 0
2:50
01 Pat:     =Bu:t, ((glances at US machine)) I was wondering if I
02          can get an ultrasound?=
03 Doc:     =Of course!
04          (1.2) ((Doc writing in chart))
05 Doc:     We'll go ahead and do that right now.
06 Pat:     °Okay,°
07          (0.8)
08 Doc:  -> An:d what about the breastfeeding class.=You missed
09       -> the breastfeeding class we had yesterday,
10          (0.2)
11 Pat:     .h I didn't know- (.) there was one,
12 Doc:     Do you wanna do one next month? We have one coming
13          up next month,
14 Pat:     Yeah,
```

The doctor's "and" preface in line 8 registers the next-on-list nature of the topic, and "what about the breastfeeding class" presents the class as something the patient should already know about and have an opinion about. Not waiting for uptake from that, she continues on with an apparent admonishment for the patient's absence from the class that occurred the day before. The patient quickly provides an account for not having been there, namely not knowing it existed (line 11). The doctor then moves right ahead to an apparent offer, though, as in the previous case, with the emphasis on "month" and not "do," she treats the patient's participation as a given. The patient agrees readily in line 13.

NOT UP FOR DISCUSSION: BIRTH CONTROL

Although overall rates of unintended pregnancy in the US have declined since 2008 (from 51% to 45%), the US has higher rates relative to other developed countries (Finer and Zolna 2011). In addition to the financial and temporal burdens associated with another mouth to feed, consequences of unintended pregnancy include higher rates of maternal depression and anxiety, strained parent-child relationships, and increased odds of romantic relationship failure (Sonfield, Hasstedt, Kavanaugh, and Anderson 2013). Low income women and women of color

have disproportionately high rates of unintended pregnancy (Finer and Zolna 2011), which contribute to shorter intervals between births (Gemmill and Lindberg 2013).

Higher levels of planning are associated with greater likelihood of contraceptive use, and this is especially crucial for patients on Medicaid and other non-private insurance, who report higher rates of misinformation and stigma surrounding birth control use, for example, endorsing the idea that planning for birth control is "for sluts" (James-Hawkins and Broaddus 2016). Both ACOG and the American Academy of Pediatrics contend that standard prenatal care should include discussion of contraceptive options and prompt postpartum birth control initiation (American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012a). Not surprisingly, the doctor in this study regularly discusses postpartum birth control with her pregnant patients.

In stark contrast to the breastfeeding class cases, the question of whether or not the mother will use birth control after delivery of the current pregnancy is not even up for debate in these visits. In the 11 cases in this sample, birth control use after birth is presupposed in 10 of them, making discussions of birth control *use* elided or very short (subsequent discussions of *which kind* of birth control to use can extend for as long as the patient has questions, giving an perception of choice while her compliance is assumed (Chappell, Toerien, Jackson, and Reuber 2018)). Analyses of birth control mentionings demonstrate that both the doctor and the patients display an expectation for birth control use after pregnancy.

The doctor initiates nine of the 11 discussions of birth control. In four of those 9 cases, she introduces the discussions independently of previous discussion in the visit, presupposing birth control use, as seen in the following two examples. In 028-01, the doctor introduces birth control after finishing the ultrasound:

Excerpt 4.9

028-01 (32 wks), no companion, return pt
Pat laying on table, Doc retrieving paper towel
Gravida 1, Para 0
6:14
01 Pat: °Everything normal?°
02 Doc .hh As near as we can tell,
03 (0.4) ((Doc places paper towel on pt's belly))
04 Doc: Go ahead and wipe off your belly.
05 Pat: °Thank you,°
06 Doc: Again the most important thing is for you not to
07 gain any more weight,
08 Pat: Yeah,
09 (2.5) ((Doc wiping off wand, pt wiping off belly))
10 Doc: -> You gonna do for birth control after the baby's born.
11 Pat: I wanted to do the um::
12 (1.4) ((pt wiping off hands))
13 Pat: The implant?

After finishing the ultrasound and reiterating the importance of not gaining more weight, which had been discussed earlier in the visit, the doctor pauses speaking while cleaning up the ultrasound machine, then asks about birth control in line 10. "You gonna do" elides the "What are," and asking what the patient is "gonna do for birth control" presupposes not only that she will be using birth control, but also that she has a particular option in mind. "After the baby's born" locates the activity at the heart of the decision in the future, at the start of the post-pregnancy period (as the baby being born ends the pregnancy). Despite the quick transition to a new topic, the patient has a ready answer in line 11, although she does exhibit delay in coming up with the right term for Norplant, the continuous-release hormonal birth control implant. Her use of "wanted to do" suggests she is submitting a candidate answer for the doctor's approval, but she does not treat the question as unexpected.

In 018-01, the doctor asks about birth control after a discussion of the patient's ongoing nausea:

Excerpt 4.10

018-01 (11 wks), no companion, return pt
pt seated on table, doc seated on stool facing pt with chart
Gravida 1, Para 0
2:56
01 Doc: Alright,=well I'll give you some other medicine,

```
02 Pat:     Uh-huh,
03 Doc:     And we'll see if that'll help,
04 Pat:     O:kay.
05          (1.1)
06 Doc:  -> An:d what do you wanna do for birth control after °th'°
07       -> baby's born.
08          (0.4)
09 Pat:     Uh::m I was: gonna ask about- different types of birth
10          control?
11 Doc:     [Uh-huh,]
12 Pat:     [And whi]ch one was the best one.
```

After the doctor promises the patient new nausea medication, she introduces birth control in lines 6-7 with an and-prefaced question, indicating a next-on-list quality. "What do you wanna do for" solicits preference rather than plan, but the rest of the statement, "birth control after the baby's born," follows the same form as the previous example and the other two unconnected initiations. After a short delay of silence and "Uhm," the patient states in lines 9-12 that she "was gonna ask" about her options, providing an account for why she does not have a candidate choice now. Although she does not yet have a preference, she displays having thought about it, and stating that she was "going to ask" suggests that the doctor's question possibly pre-empted her own initiation of the topic.

The other five doctor-initiated birth control discussions arise in the context of ongoing discussion. Four of those five also presuppose birth control use. Two of the four involve either pregnancy termination or loss. In 020-01 below, the doctor broaches birth control after ascertaining that the patient, who has just miscarried, does not want to try to get pregnant again:

Excerpt 4.11

020-01 (1st trimester loss), no companion, return pt
Patient laying on table, Doc starting ultrasound
Gravida 1, Para 0
2:40

```
01 Doc:     Well we can check a pregnancy test again:, see
02       -> if it's gone to negative, and do you want to try to
03       -> get pregnant again then?
04 Pat:     NO.
05          (0.5)  ((Doc prepping ultrasound machine))
06 Doc:  -> What do you want to do for birt[h control.]
07 Pat:                                    [ Heh — heh]-heh! .hh >I
```

```
08          don’t wanta- I don’t wanna< go through:,
09          (0.2)
10 Doc:     This [ again.  ]
11 Pat:          [(Nuthin’)] I w- I just wanna get li:ke, this
12          taken care of I wanna get the fibroids taken care of I
13          jus:, .hhh    ((wand on belly))
```

This patient has come to the clinic today to confirm her suspicion that the pregnancy has been lost. She has described going to another clinic and being told that a fetal heartbeat was not detected. The doctor responds in line 1 that “we,” meaning the clinic, can perform a urine pregnancy test like they would have done in her initial visit, to “see if it’s gone to negative.” She then adds an and-prefaced question, “And you do you want to try to get pregnant again?” As this has just followed a “we can” declarative with a plan for a particular action, which ended with comma intonation, the question is hearable as a pre to another plan for action. The patient responds emphatically with “NO,” and then the doctor reveals where she was going: “What do you want to do for birth control” (line 6). As this is still another question rather than a specific plan, it is hearable as another pre on the way to declaring which specific birth control the patient will use. Still, like the examples above, it presupposes that the patient will use birth control (and since it does not include a reference to a future time, it implies immediacy). Interestingly, this patient here does not have a ready answer to the question. She begins with laughter in line 7, indexing a mismatched response, then provides a statement that is hearable as further explanation of her answer in line 4, followed by a statement of desire to get both this failed pregnancy and her uterine fibroids “taken care of” (lines 11-12), which serves as an account for why she has not yet chosen a birth control method.

The other two contextually-embedded doctor-initiated birth control introductions involve patients who have declared that they don’t want any more children after the current pregnancy. In 001-03, the doctor then offers a permanent birth control option:

Excerpt 4.12

001-03 (11 wks), no companion, return pt
Patient seated on table, Doc leaning against counter facing pt
Gravida 3, Para 2
3:29

```
01 Doc:     If you: don't wanna take that risk you are absolutely
02          entitled to have another C section.
03 Pat:     .h Okhay:, okha[y:.
04 Doc:                    ['N you don't have to decide right now
05          [you're just- [early.]
06 Pat:     [  I    know, [(eah),] .hh y'h.
07 Doc:  -> Do you think you want more children after this one?
08 Pat:     No:: this is it.
09 Doc:  -> Do you want your tubes tied, at the s[ame time?]
10 Pat:                                          [Yes  mam.]
11 Doc:     A[s the C section?]
```

The patient and doctor have been discussing vaginal delivery versus C-section. The doctor moves to close that discussion in lines 4-5 by emphasizing that the patient doesn't need to make that decision yet. The patient demonstrates understanding in line 6, and then the doctor shifts focus to the question of more children in line 7. The patient answers quickly and firmly in the negative, and the doctor continues with "Do you want your tubes tied, at the same time?" in line 9. This is an offer for tubal ligation, and "at the same time," as made clear in the increment in line 11, refers to the C-section. This offer makes the doctor's question in line 7 now hearable as a pre, and knowing the patient does not want any more children not only makes the use of birth control obvious, it also provides justification for the doctor to jump right to offering an irreversible option. The patient responds even more emphatically with "Yes mam" in line 10, before the doctor has even finished her tubal ligation question.

In only one case where the doctor introduces birth control in context of ongoing discussion, she does not presuppose birth control use. This is the only time this happens in this sample. In 003-01, the patient has lost the pregnancy, but is unsure of whether or not she and her partner will keep trying immediately for a baby:

Excerpt 4.13

003-01 (1st trimester loss), companion present, returning pt

```
Pat seated on table, comp in chair, doc leaning on counter facing pt
Gravida 2, Para 0
2:01
01 Doc:     So if you're: emotionally ready, to[:,
02 Pat:                                       [hhhh[h ((nasal exhale))
03 Doc:                                            [Try again,
04          then you're welcome to try again. >As long as you have
05          a negative pregnancy test and the-< .hhh pregnancy test
06          was negative here as well.
07 Pat:     °Mkay.°
08          (3.8)  ((Doc looks down to chart, flips though))
09 Doc:  -> If you want to wait? Did you need assistance with any,
10       -> contraception?
11          (1.0)
12 Pat:     tch Uh:: yeah: -would like to start taking my birth
13          control again,
14 Doc:     Okay, .hh Do you have the pills at home or do >you
15          need a< prescription.
```

This patient and her partner are in clinic to confirm their second pregnancy loss. The doctor and patient have been discussing whether there is any reason to wait before trying again for a pregnancy after a loss. The doctor has explained that, although some doctors think patients should wait to let the mother's body recover, she doesn't see any reason to wait, given that the pregnancy was not very far along. She moves to end her explanation of waiting versus not waiting in lines 1-6, telling the patient she is "welcome to" try again on condition that she is emotionally ready and that she has a confirmed negative pregnancy test, which she does. The patient does not reveal whether she intends to try again or not, offering only an audible exhalation after "emotionally ready" in line 2, and a quiet, shift-implicative information receipt in line 7. The doctor looks through the chart, and then inquires about birth control. She begins with a conditional "If you want to wait" in line 9, sensitive to the patient not having revealed whether or not she will wait. She then delivers an offer, "Did you need assistance with any contraception?" Not only does this offer not presuppose birth control use, its negative polarity item ("any contraception") actually builds it for a negative response. This stands in stark contrast to all the other doctor-initiated birth control introductions. However, it becomes clear that the

doctor chooses to deliver her offer this way due to recipient design. By offering "assistance with" contraception, rather than contraception itself, the doctor leaves room for the possibility that the patient may not need assistance – in other words, that the patient may already have some means of birth control available. The patient responds to the offer of assistance with "Yeah" in line 12, but adds that she would like to start taking "my birth control again," which suggests she may indeed have some at home already. This makes it unclear of whether she needs a new prescription or not, so the doctor follows up with a question to that effect in lines 14-15. Thus the doctor's negatively polarized offer in lines 9-10 makes sense in light of her hunch that the patient may already have birth control pills at home (which, as it will turn out, she does, but still needs a new prescription).

The doctor is not the only person who will introduce birth control into discussion. Patients will also bring it up, and in this sample, they do so twice (two of the 11 introductions of birth control). Both cases demonstrate an expectation for birth control use after the pregnancy. In 016-01, the patient is motivated to initiate discussion of birth control due to having polycystic ovary syndrome, or PCOS.

Excerpt 4.14

016-01 (37 wks), companion present, return pt
Patient seated on table, companion in chair, doc at table with chart
1:52

```
01 Doc:     So- that d̲ifferenc[e?=is consistent with the pregnancy.
02 Pat:                       [Okay. ((Doc to counter with chart))
03          (1.8)  ((Doc at counter, flipping through chart))
04 Doc:     Any other q̲uestions those are good question[s,
05 Pat:  ->                                            [Yes
06          uh::m: when: I have the baby aft[er the ba]by=
07 Doc:                                     [Uh — huh,]
08 Pat:  -> =you know how you have the:: pos:t um:
09       -> appointment or whatever,=
10 Doc:     =Uh-huh post[partum,]
11 Pat:  ->              [ Uhm-  ] nDo: you: give the birth
12       -> control h̲ere because I have poliocystic syndrome
13       -> and that's why I was taking Metf̲ormin in
14       -> [the begin]ning of my=
15 Doc:     [  . h h  ]
16 Doc:     =Ri[g h t ,]
```

```
17 Pat:  ->    [pregnan]cy,=
18 Doc:     =[Right,]
19 Pat:     =[ . h h] So I'm worried tha:t, (0.3) n:ot
20          getting back on it? That I'm: just gonna continue:-
21          (0.4) gaining weight cause: when I had my first child
```

Wrapping up a discussion of previous lab results, the doctor reassures the patient that her results are normal. After indicating her acknowledgement of the reassurance ("Okay"), a bit prematurely, in overlap with the doctor's concluding statement, the patient remains silent. The doctor then offers a pro forma solicitation for additional questions in line 4 – "Any other questions", with the negative polarity item "any" tilting the grammatical preference towards no further questions. But she also through-produces the positive evaluation "those are good questions," in effect praising the patient for having raised questions about her lab results. The patient is ready with her next question, coming in just slightly in overlap with the end of the doctor's evaluative comment. Her "Yes" in line 5 serves as the (grammatically dispreferred) response to the yes/no question "any other questions". Now with the floor, she finds herself having trouble getting her question out, as evidenced by the elongated "uhm". Then she sets up the postpartum context for her question, which she also has trouble with, correcting "when I have the baby" to "after the baby" in line 6. After the doctor's go-ahead "uh-huh," the patient then evokes the postpartum checkup visit in lines 8-9, also with considerable trouble. After the doctor indicates understanding and corrects the patient's phrasing "uh-huh postpartum," the patient finally asks her additional question in lines 11-12. She has some trouble in the beginning, starting with "uhm" and elongating her first two words, but then gets to the heart of her question ("give the birth control here"). The patient's phrasing of it as "the" birth control indicates that she takes it for granted that she will take birth control after delivery, she merely needs to know if it is "given" here or if she will obtain it somewhere else. She then immediately justifies her question with an extended account of a relevant condition ("polycystic syndrome") and past

experience (weight gain after her first child). In this case, then, the patient's initiation of the birth control discussion is out of the blue in that birth control has not already been made relevant. Although the doctor does offer a generic solicitation for further questions, she does nothing to indicate that birth control specifically should be discussed. The patient's ready initiation and subsequent lengthy justification (which continues on after this excerpt) indicate not only that birth control is a pressing matter for her, and that she is being a proactive patient in addressing the matter now, but also that she expects to go on birth control after delivery.

In 021-01, the patient initiates discussion of birth control after this pregnancy after the doctor has made it relevant in asking about birth control after her previous pregnancy:

Excerpt 4.15

021-01 (18 wks), no companion, new pt
Patient lying on table, Doc performing ultrasound
Gravida 4, Para 3
4:11

```
01 Doc:  -> Did Doctor Lin offer you different birth
02       -> control?
03          (0.6)
04 Pat:     Uh::m,
05          (0.8)
06 Pat:  -> I think I seen 'im:: month after: an::d .hh We
07       -> were actually talking about getting tubes tied.
08 Doc:     Uh-huh,
09          (0.2)
10 Pat:     And then: I think I jus: didn't go with him
11          anymore and then: (0.4) I got? (0.5) laid off from
12          work?=And that's whe[n I found o]ut I was pregnant=
13 Doc:                          [ O h : : , ]
14 Pat:     =(°I [thought coo:]:l:,°)
15 Doc:          [  Oh  wo:w, ]
16 Doc:     Well that's a bummer,
17 Pat:     Yeah,
18 Doc:     But well, well it gives you free time.
19 ((24 seconds - discussion of ultrasound in progress))
20 Doc:     tch There's the long bone of the leg I'm just
21          going to measure this this way it's a little bit
22          easier if (.) I turn this,  ((turns monitor away from pt))
23 Pat:  -> °Okay,° .hh Um do you guys have that option:
24       -> here? To: tie it,
25 Doc:     Yes you can get your tubes tied if you go to the
26          Martin Luther King hospital you can get them tied
27          immediately after delivery, even if it's a
28          vaginal delivery.
```

This patient is new to this clinic, and the doctor has spent a lot of time discussing her previous pregnancy, which the patient received care for at another clinic. Because this pregnancy followed the patient's last one very quickly, the doctor has already asked about birth control after the last pregnancy. Here, the doctor inquires as to whether the previous doctor offered different birth control from what the patient had been on before, while prepping the patient for an ultrasound examination. The patient reports in lines 6-7 that at the postpartum visit (a month after the birth), she and the previous doctor had discussed the possibility of the patient getting a tubal ligation ("getting tubes tied"). The doctor offers a continuer indicating she is following the patient's meaning ("uh-huh"). Tubal ligation would require returning to the clinic for a procedure, as opposed to going on hormonal birth control, the prescription for which could have been obtained in her postpartum visit, and the patient then offers a vague and noncommittal account for why she didn't return to the previous doctor after that in lines 10-11 ("I think I just didn't go with him anymore"), followed by a more specific account for why she never saw that doctor again – she "got laid off from work," which left her without access to that doctor through her insurance. Thus, though the patient could demonstrate that she was responsible enough to have thought seriously about permanent birth control to prevent more pregnancies, she had at least one valid reason for not following through with the procedure. It comes as no surprise, then, nearly thirty seconds later, as they are engaged in the ultrasound, when the patient inquires about tubal ligation as a possibility after this pregnancy in lines 23-24. Because the doctor shifted focus quickly to the ultrasound, focusing the patient's attention on the images on the screen, the patient was occupied in the ultrasound and so did not continue the discussion of birth control. But once the doctor turns the screen more towards herself and away from the patient to better take fetal measurements (which she narrates with "it's a little bit easier if I turn this" in lines 21-22, the

"this" being the screen), the patient takes advantage of her lack of occupation to turn the conversation back to birth control, specifically, getting a tubal ligation after this pregnancy. She does so by inquiring if "you guys," the clinic, "have that option." As nearly thirty seconds have intervened between the discussion of birth control and this locally subsequent reference, she immediately clarifies what she means by "that option" with "to tie it". Although "it" is still left unclarified, the verb "tie" is all the doctor needs to recognize this as a return to discussion about tubal ligation, and she replies readily in lines 25-28, confirming that that option is available ("you can"), mirroring the patient's earlier phrasing ("get your tubes tied"), and following immediately with another possibility for a procedure done immediately at the time of birth (as opposed to after the postpartum visit, as the patient had discussed with her previous doctor) at one of the particular hospitals this doctor delivers at. Here, then, the patient's inquiry about tubal ligation is not surprising, given that the detailed discussion of events after the last pregnancy had not only made it relevant, but also implied that birth control after this baby is expected.

A BALANCING ACT: PERTUSSIS VACCINE

Pertussis, or whooping cough, is a respiratory illness that causes coughing spells so severe that it can make it hard for infants to eat, drink, or breathe, and can cause pneumonia, seizures, brain damage, or death (Centers for Disease Control and Prevention 2017). Both ACOG and the Centers for Disease Control and Prevention (CDC) recommend that pregnant women receive pertussis vaccinations (Tdap) between the 27th and 36th week of pregnancy to protect the baby immediately after it is born (as babies do not receive their own vaccinations until two months of age). Women are encouraged to receive the vaccine at each pregnancy, even if they have received it in a previous pregnancy (American College of Obstetricians and Gynecologists

2017c; Liang, Tiwari, Moro, Messonnier, Reingold, Sawyer, and Clark 2018). There is no evidence of adverse fetal effects resulting from the pertussis vaccine in pregnancy (American College of Obstetricians and Gynecologists 2017c).

A recent CDC study reports a pertussis vaccination rate during pregnancy of 54%, with 67% of mothers reporting being offered the vaccine in clinic (of those, 74% accepted it). Among mothers who declined the vaccine, the most common reason cited was not knowing they should get it, and concern of safety risks to the baby was the second most common reason (Centers for Disease Control and Prevention 2018).

Concerns over risks are linked to a public perception that major controversies currently exist regarding vaccinations in this country. However, in reality, vaccine risk is *not* a major concern for most people in the US, and is not characteristic of any major demographic group (Kahan 2014; Pew Research Center 2015). Still, not everyone agrees that vaccines should be made mandatory, and there is some evidence for an age effect. According to a national survey by the Pew Research Center, 37% of US adults under age 50 say vaccination should be up to the parents rather than mandated, while only 22% of adults over 50 say the same (Pew Research Center 2015).

There is strong evidence that health care providers have major effects on vaccinating behavior. Providers remain parents' most trusted advisor and influencers regarding vaccination decisions, despite increases in workload and constraints on time and resources that stretch providers' capacity (Kennedy, Basket, and Sheedy 2011; Paterson, Meurice, Stanberry, Glismann, Rosenthal, and Larson 2016). Providers have a positive influence on parents' vaccination decisions, even when parents think vaccines are unsafe (Smith, Kennedy, Wooten, Gust, and Pickering 2006). Providers who listen and respond in ways that address parent

concerns about vaccines can help parents make more informed decisions (Kennedy, Basket, and Sheedy 2011), and parents who change their mind about vaccines cite reassurance and information from their provider as the main reason they decided to pursue the vaccine (Gust, Darling, Kennedy, and Schwartz 2008).

The doctor in this study consistently offers the pertussis vaccine to pregnant women between 27 and 36 weeks. Similar to the breastfeeding class and in contrast to birth control discussions, when introducing the pertussis vaccine, the doctor will use a variety of formats that index a range of patient agency in deciding whether or not to get the vaccine. Formats for these 8 cases range from solicitation of intent to pronouncement, and in one case she does presuppose vaccine acceptance, like in the birth control cases. Unlike with the breastfeeding class, here she appears to use stronger formats when the patient is an experienced mom, and has had the vaccine before in an earlier pregnancy. The pertussis cases are also unique in that we start to see a combination of formats and tactics used right off the bat to strengthen the case for vaccination.

Beginning with simpler introductions, in 016-01, the doctor first asks if the patient has already received the vaccine, as a pre to offering it:

Excerpt 4.16

016-01 (37 wks), companion present, return patient
Patient lying on table, companion in chair, Doc at counter with chart
Gravida 2, Para 1
10:00

```
01 Doc:     If she's RH positive then you'll get the RhoGAM shot
02          just like you got in the middle of the pregnancy.
03 Pat:     Okay.       ((Doc writing in chart))
04 Com:     So that would be my fault.
05 Pat:     Yes [that would be your fault.  ((to companion))
06 Doc:         [No [it's not that- that would be your genetics.=
07 Com:             [Heh   heh   heh    heh    heh
08 Pat:     =Heh heh heh heh [heh heh heh heh [heh heh heh!
09 Doc:  ->                  [Um,             [Did you get the
10       -> vaccine fer: the: the pertussis? The f- the: (.) the
11       -> whooping cough vaccine? [Did you get it (already)]?
12 Pat:                             [ N  :  :  o     I     di]dn't
13          get it.
14 Doc:  -> Would you like to get that?
15 Pat:     (It-) Yeah I think I got it last time
```

```
16          at the hospital.
```

The doctor and patient have been discussing the baby's Rhesus factor, which is relevant because the mother is Rhesus negative (so if the baby is positive, the mother would need to receive a shot to prevent reacting to the baby's blood). The baby's father jokes that a Rhesus positive baby would be "his fault" in line 4, as Rhesus status is inherited from the father. The doc responds in morally neutral terms of genetics, and as the patient and her partner laugh, the doctor attempts to move on with "Um" in line 9. Interacting with the chart, she can see a note from the previous visit that the pertussis vaccine was offered, but there was no indication that it was done. Continuing as the patient finishes laughing, the doctor inquires if the patient has already gotten the pertussis vaccine. She then restates it in common terms as "whooping cough vaccine" (line 11) and repeats the question of if the patient has already received it. The patient answers in overlap in lines 12-13, and then the doctor delivers an offer for her to get it. "Would you like," of course, suggests that the choice is entirely up to the patient. The patient starts to form an account with "I think" but then restarts with "Yeah" to accept the offer, then add an account of having received it "last time" in her previous pregnancy.

In another simple case, in 008-01, the doctor introduces the pertussis vaccine into discussion via a pronouncement, an authoritarian format (Stivers et al. 2018):

Excerpt 4.17

```
008-01 (30 wks), no companion, return patient
Patient lying on table, Doc leaning on counter, MA drawing blood
Gravida 4, Para 2
6:06
01 Doc:     They're trying to freeze us out
02          of th[e:, of the  building]
03 Pat:           [Yeah I was like it's] cold back here! eh huh huh
04          (3.2)  ((Doc watches blood draw))
05 Doc:  -> And I'm gonna send you back to the lab to get the:
06       -> vaccine?
07 Pat:     O[: kay.]
08 Doc:  ->  [For th]e whooping cough.
09          (3.4)  ((Doc looks down to chart, reads))
10 Pat:     And the whoopin- whooping cough is for: the::
11          (0.6)
```

Towards the end of the visit, the doctor is wrapping things up while the MA is in the room performing a blood draw on the patient (this is unusual). The patient has commented on how cold it is in the building, and the doctor responds cordially. After a pause in line 4, the doctor adds an intention to send the patient "back to the lab" down the hall from the clinic room to "get the vaccine" in lines 5-6. The pronouncement format, combined with a locally subsequent reference ("the vaccine,") suggests that the vaccine has already been discussed, but this is not quite the case. At the start of the visit, the doctor asked the researcher to go ask the lab to bring a vial of the T-Dap vaccine to the exam room. This was done in front of the patient, though the doctor did not address the patient, nor did the patient respond in any way. Here, the doctor refers to the vaccine using what Opel and all describe as a "presumptive" format, presupposing agreement (Opel, Robinson, Heritage, Korfiatis, Taylor, and Mangione-Smith 2012). The patient agrees readily before the doctor has even specified which vaccine with period-intoned "Okay" in line 7. The doctor adds an increment in line 8 to specify the vaccine, but having already received agreement, does not continue, and instead looks down to the chart. After a lengthy pause, the patient begins to question the vaccine in line 10 (which will then prompt the doctor to deliver all kinds of justifications).

In 024-01, the doctor confirms the patient's having rejected the pertussis vaccine at a previous visit:

Excerpt 4.18

```
024-01 (32 wks), companion present, return pt
Patient seated on table, companion in chair, Doc at table with Doppler
Gravida 3, Para 1
4:11
01 Doc:     I'm hearing the heartbeat (.3) below the belly
02          button,
03          (0.8) ((listening to HB on doppler))
04 Com:     Hmm hmm hmm!
05          (0.8)
06 Doc:     And let's look and see where the head is,
07          (0.5) ((Doc to paper towel, then counter))
```

```
08 Pat:     °(Okay)°
09          (3.5)  ((Doc wipes off Doppler while reading chart))
10 Doc:  -> And I understand that you did not want to do the:
11       -> vaccination for the pertussis for the whooping cough?
12 Pat:     Right.  ((Doc to ultrasound machine))
```

At the start of this excerpt, the doctor is checking for fetal heartbeat with the Doppler device. After confirming that she can hear the heartbeat in line 1, she delivers an and-prefaced "let's" proposal to shift gears (Stivers and Sidnell 2016) to "look and see" fetal position on ultrasound. But before she moves to the ultrasound, she looks at the chart on the counter and sees that the patient has previously declined the pertussis vaccine. The doctor then introduces it by checking to see if her understanding that the patient has refused it is correct. "And I understand" (line 10) references the doctor having learned of the patient's wishes from another source (in this case probably the chart). "You did not want to do the vaccine for the pertussis," a solicits confirmation from the patient in the form of a negative declarative, indexing the doctor's relatively high epistemic position on the patient's wishes. This type of introduction also represents a kind of "participatory" format, giving the patient more opportunity to be involved in the decision (Opel et al. 2012). The patient easily and simply confirms the doctor's understanding with period-intoned "Right" in line 12. (Of note, the doctor will then pursue the patient's reasoning, and this becomes the longest discussion of the pertussis vaccine, spanning the entire length of the ultrasound and lasting over six minutes in total.)

Unlike the cases for either the breastfeeding class or birth control, for the pertussis vaccine, the doctor will often use a combination of formats to introduce the topic. She does this in four out of the 8 cases. In 027-01, she starts with a solicitation of patient interest, but then adds what appears on the surface to be an offer:

Excerpt 4.19
027-01 (25 wks), no companion, return patient
Patient seated on table, doctor on stool with chart

```
Gravida 2, Para 1
11:10
01 Doc:     Do you wanna come back in about a month? Would that
02          work for you?
03 Pat:     M-hm,
04 Doc:  -> And then what about the T-dap vaccine. Do you wanna do
05       -> that now or when you come back in a month?
06          (0.8)  ((Patient and doc looking at each other))
07 Pat:     *tch  ((Patient cocks head))
08 Doc:     It's the pertussis vaccine it's recommended for all
09          pregnant women at every:,
10          (0.6)
11 Pat:     Oh [ yeah okah- I: [was jus-
12 Doc:        [Um:,           [Pregnancy?)
13 Pat:     Okay. Cause I did have it before so. ((straightens head))
```

As the doctor is wrapping up the visit, she introduces the pertussis vaccine in line with a patient view elicitor (Chappell, Toerien, Jackson, and Reuber 2018), "And then what about" in line 4. She also refers to it as "the T-dap vaccine," rather than her more commonly used "pertussis" or "whooping cough." This sentence suggests that the vaccine is something the doctor and patient have discussed before, although there is no evidence of that in this visit (although it may have happened in a previous visit). But before the patient can respond to that with her inclination, the doctor adds in lines 4-5 what appears to be an offer, but actually presupposes that the patient will get the vaccine (as she usually did for birth control, as seen in the last section). "Do you wanna do that now or when you come back in a month," in addition to being presumptive (Opel et al. 2012), is an option listing that gives the patient the illusion of choice for timing of the vaccine, but not the vaccine itself[5] (Chappell, Toerien, Jackson, and Reuber 2018). The patient does not respond for nearly a second, then cocks hear head and starts with a "tch" sound in line 7, but the doctor tries again with clarification "It's the pertussis vaccine" and a recommendation (lines 8-9). This appears to be enough for the patient to recognize, and she displays recognition in lines 11-13, noting that she had it "before," during her last pregnancy.

[5] Note the contrast here with the solicitation + true offer combination used in the breastfeeding class case 027-01 – the same patient!

In three cases, the doctor begins with either a solicitation of inclination or an offer, plus a recommendation. We see one example here in 010-01:

Excerpt 4.20

010-01 (27 wks), companion present, return pt
Patient seated on table, companion in chair, Doc at counter with chart
8:43
01 Doc: And your urine looks fine,
02 (0.8)
03 Doc: -> Um did you- wanna get thee: vaccine, for the whooping
04 -> cough? We r[ecommend it fo]r everybody.
05 Pat: [m m -m m m] ((soft throat clear))
06 (0.6)
07 Pat: tch .hh Um::,
08 (0.6)
09 Doc: And we recommend it for pregnant ladies: starting at
10 twenty seven weeks which is where you are now by our
11 best estimate,
12 Pat: Okay,

Towards the end of the visit, the doctor is recording measurements from the just-completed ultrasound in the chart. She notes that the urine sample that the patient gave upon arrival "looks fine," and then continues by soliciting the patient's interest in the pertussis vaccine with participatory format (Opel et al. 2012), in lines 3-4. Similar to 027-01, the doctor does not treat this solicitation alone sufficient, and again adds another tactic, in this case a vague recommendation (line 4). The patient stalls with silence, an "Um," and more silence, which acts as a form of resistance (Heritage and Sefi 1992), consistent with Opel et al's finding that parents are more likely to resist vaccines when participatory format is used (Opel, Heritage, Taylor, Mangione-Smith, Salas, Devere, Zhou, and Robinson 2013). The doctor continues by adding detail to the recommendation in lines 9-11. She specifies the timeframe that "we" recommend it, and adds that the patient now currently falls within this timeframe. This finally gets a response from the patient, a possibly compliant "Okay" with comma intonation in line 12, which could also be just an information receipt. (The doctor will go on to pursue a more definitive

agreement.) The doctor uses this same combination of tactics in two other pertussis introductions (resulting in future compliance in one, and resistance in the other).

In one interesting case, 007-01, the doctor effectively defers the burden of the pertussis discussion until the next visit:

Excerpt 4.21

```
007-01 (27 wks), companion present, return patient
Patient laying on table, companion in chair, Doc seated on stool with chart
Gravida 1, Para 0
22:54
01 Pat:     And: the weird thing is that- my body did know.
02 Doc:     [Yeah!
03 Pat:     [Cause: it didn't let me- drink anymore didn't
04          let me: do anything,
05 Doc:     Yeah, so that was good!
06 Pat:     M-[hm
07 Doc:       [And you listened to you.
08 Pat:     Yep. hh
09 Doc:  -> Um- so I was: going to offer you the vaccine against
10       -> the pertussis but you probably don't- that's to prevent
11       -> a different kind of cough. Ad- [nd-
12 Com:                                    [Mm,
13          (0.6) ((Patient makes teeth-bearing unimpressed face))
14 Doc:     You know, well lemme give you the information sheet.
15 Pat:     Okay,  ((Patient closes mouth, nods))
```

This patient has already been talking with the doctor for over twenty minutes, and most of that time has been spent addressing a complaint the patient has with the clinic's nurse midwife, whom she saw at her last visit. To say it has been a highly contentious visit would be an understatement. The patient also has a cold, which she is clearly exhibiting uncomfortable symptoms from. At the start of the excerpt, the patient is describing having known she was pregnant before receiving any medical confirmation. The doctor praises her for listening to her body in lines 5 and 7. Sitting at the counter with the chart before her, the doctor then introduces the idea of the pertussis vaccine in a heavily mitigated way to demonstrate her sensitivity to the patient's current discomfort (probably as well as time already spent at the clinic that day, which was another patient complaint addressed). "So I was going to" in line 9 indexes that the doctor has changed her mind about a course of action. "To offer you" indicates that whatever it was

going to be would be in the patient's realm of decision. So by the time she gets to the meat of the offer, "the vaccine against the pertussis," she has already shown considerable deference to the patient's possible unwillingness. Still, she appends even more at the end with "but you probably don't- that's to prevent a different kind of cough" (lines 10-11), nearly stating aloud her hunch that the patient wouldn't agree to do it, and acknowledging the patient's current state by describing pertussis as "a different kind of cough." Although there is still opportunity for the patient to state interest in or agreement to the vaccine, the doctor has made it very easy to not comply, and the patient offers no response to any of this except for a face she makes, looking at the doctor with bared teeth, and the doctor quickly defers to offering the patient an information sheet to read about the vaccine instead in line 14.

DISCUSSION

As can be seen in the above analyses, both the doctor and the patients orient to the breastfeeding class, birth control use, and the pertussis vaccine in different ways. The doctor forms the introductions of the topics in ways that suggest different degrees of deontic authority allowed for different decision types. These differences perhaps reflect larger societal orientations to – and concerns about – each activity.

In the case of the breastfeeding class, the doctor makes a consistent point to offer it, often in lieu of addressing intentions to breastfeed in general. But generally, she does not press very hard for patient participation. This may be less true for new mothers, however, who appear more likely to receive stronger formulations than experienced moms. This perhaps contributes to new moms' apparent willingness to agree quickly to the class. The doctor's choice to focus on the class rather than breastfeeding itself (which here we only ever see mentioned as a pre to introducing the class) shows that she values breastfeeding education, which, as noted before,

research suggests is helpful in increasing breastfeeding rates (Chezem, Friesen, and Boettcher 2003). And breastfeeding, in turn, offers many benefits for both the baby and the mother. Focusing on the class rather than on breastfeeding itself may also have interactional benefits. Committing to breastfeeding requires long-term effort, determination, and even more of a lifestyle modification than a new baby itself imposes. Committing to a breastfeeding *class*, however, given by the same clinic that conducts their prenatal care, requires little more time than the patient is already spending for her regular prenatal visits. The doctor's ultimate goal may be breastfeeding itself, but, knowing class utilization makes it more likely for women to actually breastfeed, she may find focusing on the class to be easier, given that it would appear less daunting or imposing on the patient.

Birth control use is demonstrably not up for discussion, as nearly every time the doctor introduces it, she presupposes patient use. Given the high proportion of patients without private insurance, her prerogative for "duty of care" (Chappell, Toerien, Jackson, and Reuber 2018) may combat stigma and misinformation to lessen the chances that these patients wind up not using birth control postpartum (James-Hawkins and Broaddus 2016). For their part, the patients also display an expectation for birth control use, in their responses to the doctor's introduction, and in their own introductions. This may well be due to prior use, which also suggests that (re-) initiation of birth control after delivery would not be much of an imposition on them.

Pertussis introductions have elements similar to both the breastfeeding class and birth control cases, and yet are not quite like either of them. The doctor cannot demand that the patient receive the vaccine, so emphasis on offering is common, sometimes with questions that solicit how the patient *feels* about the vaccine. This may be a nod to the need to inform patients of its existence and importance, while also being sensitive to possibility that they may have strong

feelings against it, as a significant proportion of younger adults do (Pew Research Center 2015). In this way, pertussis appears to be most similar to the breastfeeding class (although, past the introduction, the doctor will go on to pursue compliance with the vaccine in ways she does not do with the breastfeeding class). Yet, as a clinician who views the vaccine as an imperative (not to mention something that can be taken care of quickly in clinic), the doctor will sometimes declare that the patient will get it, or even presuppose it, like she does with birth control. These findings are consistent with Opel et al's work on "presumptive" vs. "participatory" formats (Opel et al. 2013; Opel et al. 2012), which has shown that parents are more likely to resist in response to "participatory" formats – but also that initially resistant parents will often ultimately accept if the doctor continues pursuit of acceptance beyond initial resistance (Opel et al. 2013; Opel, Mangione-Smith, Robinson, Heritage, DeVere, Salas, Zhou, and Taylor 2015). Patient experience again appears to play a role, with more experienced patients receiving stronger formulations – presumably because they have received the vaccine before and should therefore be familiar with it. So her mix of low-pressure and high-pressure tactics is a bit of a puzzle, but perhaps is not surprising given the current confusion over mixed national attitudes towards vaccines.

In conclusion, then, decision discussion introductions display a wide range of strategies that establish varying degrees of deontic authority for the patients. These different treatments of different future action types appear to reflect not only official recommendations but also current patient orientations, questions, and possible concerns. This suggests that both the doctor's allowance of patient agency and the patients' level of passivity vs. activity may not be one-size-fits-all, but instead may vary according to what is being discussed – resulting in different

amounts of agency being granted to or claimed by the patient within the same visit, as well as differing amounts from patient to patient.

Chapter 5. Maintaining a "Worry-Light" Environment

A recent study by Nishizaka (Nishizaka 2017) demonstrates how concern and relief are justified by participants engaging in discussions of radiation exposure in Fukushima Prefecture. In elucidating how the expression of worry is morally constrained in interaction, he describes the interactional practices participants use create an arena to express an appropriate – but not excessive – amount of worry. His work follows in the vein of that done on troubles talk (Jefferson 1984; Jefferson 1988) and delivery and reception of bad news (Maynard 2003) to illustrate the various ways emotions are managed systematically in everyday life.

When applying Nishizaka's ideas to the data in this dissertation, a curious thing happens: Very little worry or concern is readily apparent. Given that patients are concerned for their babies' health, and doctors are concerned for mothers' health, one would expect to find markers of worry in their interactions. But examining the data reveals that worry does not come to the surface that often – indeed, most of the time, during routine discussions, concern seems only to be hinted at, giving the impression of a "worry-light" environment.

More worry may emerge and become quite explicit in unusual or non-standard discussions, especially when a patient brings up a specific concern (for example, a patient who is overly worried about miscarriage because her aunt once had one), or when the doctor is concerned about a patient's particular condition (like diabetes or high blood pressure). Those cases, similar to the kind investigated by Nishizaka (2011b) in an analysis of pregnant women's concerns through problem presentation, are not the focus here. This chapter examines construction of routine procedures and testing in patients whose pregnancy has been progressing normally (visit N=27, excluding two miscarriages and one termination discussion).

Investigating worry within routine, unproblematic pregnancies may not at first appear to be analytically rewarding, as truly worrisome circumstances do not usually arise. However, the *potential* for worry is ever-present even in unproblematic pregnancies. Because human beings bring a "why that now" orientation to every interaction (Schegloff and Sacks 1973), and owing to a commonsense understanding that doctors are generally on the look out for problematic conditions as a main focus of their job, any question asked by the doctor, or any procedure implemented or reviewed, could stimulate worry in the patient, whose main concern is, of course, the health of her unborn baby (no trivial matter). Maynard has noted how, similar to everyday life, participants in medical interactions orient to a "benign order of everyday life," shrouding bad news and highlighting the unproblematic or good (Maynard 2003). Even in routine primary care checkups, doctors have been shown to offer commentary which serves to reassure the patient that nothing is wrong (Heritage and Stivers 1999). With the stakes so much higher here, it is reasonable to think that the doctor may similarly incorporate tactics that reassure the patient that her baby is just fine, and close analysis of interactions within unproblematic pregnancies reveals that this is indeed the case.

Mitigation of worry can happen during any activity in the patient visit, but for this chapter I focus on specific, common procedures, in particular: routine bloodwork (16 discussions), measurement of fundal height using tape measure (12 measurings), and heartbeat detection using Doppler (17 detections).[6] I analyze how the production of testing and procedures demonstrates features of a "worry-light" environment, including:

- The matter-of-course introduction of procedures and testing
- In-the-moment reassurance of normality via positive assessment
- Use of medical knowledge as a tool to assuage possible concern

[6] Ultrasounds would also fit the bill of a routine prenatal procedure, but because of their unique duality (which I discuss in Chapter 3), I omit them here.

- Minimal (or absent) patient response
- Explicit resistance to claiming worry

These features are highlighted by examining testing and procedures at each phase in the process, namely when they are introduced, as they are conducted, and in post-hoc review.

For the data in this chapter, transcript excerpts will be labeled as follows:

Line 1: Visit # (weeks gestation), if companion present, new or return patient
Line 2: Physical orientation of individuals in room at start of transcript
Line 3: Gravidity (# pregnancies, including this one) and Parity (# births experienced)
Line 4: Time elapsed in visit at start of transcript

Example:

```
024-01 (32 wks), companion present, return pt
pt seated on table, comp in chair, doc at counter with chart
Gravida 3, Para 1
0:52
```

INTRODUCTION OF PROCEDURES AND TESTING: A MATTER OF COURSE

When introducing standard procedures and testing, the doctor does so in a manner that portrays them as a matter of course, and not made a big deal of. Measurement of fetal size using tape measure over the belly and detection of fetal heartbeat via Doppler (which usually both occur in the same visit) are typically introduced together in a straightforward manner, as seen in 009-01:

Excerpt 5.1

```
009-01 (27 wks), no companion, return patient
Patient seated on table, Doc at counter with chart
Gravida 3, Para 1
1:57
01 Doc:     And your blood pressure looks great today:, and
02          the urine is=
03 Pat:     =Mm,
04 Doc:     Clean, nothin' in it,
05          (1.8)  ((Doc looking in chart))
06 Doc:  -> So let's listen to the heartbeat and measure
07       -> your belly.
08          (2.5) ((Doc opens drawer and grabs Doppler))
09 Doc:     Which hospital you wanna go to,
```

The doctor has just reviewed the patient's weight gain, showing the patient her progress in the chart and assuring her that she is gaining enough weight. Just before the start of this excerpt, she walks to the counter and sets the chart down, looking in it as she continues talking in line 1. After positively assessing the patient's blood pressure and urine, the doctor pauses while continuing to look in the chart, then proposes ascertaining fetal heartbeat and measuring the patient's belly in line 6. "So" indexes that her utterance, in this case a "let's" proposal for new collaborative activity (Stivers and Sidnell 2016), follows in consequence to the utterance prior – namely, because the test results were not concerning, they can move on to something new, and this has been on the agenda (Bolden 2006). In this way, the doctor indexes the shift to next activity as a routinized, unproblematic follow up to the previous, equally unproblematic exchange.

"Listen to the heartbeat" is this doctor's most common formulation for ascertaining fetal heartbeat, and framing it in this way elides the possibility that the doctor may hear something that raises concern – simply "listening" is presented as the purpose, rather than checking for problems. "Measure your belly" is also her typical way of formulating fundal height measurement, and the simple, literal description leaves it up to the patient to infer the reason for measuring: to track fetal growth from visit to visit and compare to expected size for fetal age. The patient offers no uptake or reaction whatsoever, not even nonverbally. This is also quite common. The doctor does not treat the patient's lack of response as problematic, and moves right ahead with retrieving the Doppler device and tape measure from a drawer. Not needing to further justify or explain the imminent activity, she moves on in conversation to another matter, in this case the patient's preferred hospital for delivery, in line 9.

Measurement and heartbeat detection are always introduced shortly before they are preformed, but bloodwork is often introduced at the visit prior to when it will actually happen. This is because blood is typically drawn by clinic staff in a lab room immediately after the patient checks in, before she is roomed in an exam room for the doctor to see. The doctor often does not mention future bloodwork at all, but she does foreshadow it in some cases, for example 015-01:

Excerpt 5.2

015-01 (23 wks), companion present, return patient
Patient seated on table, doc at table, companion in chair
Gravida 1, Para 0

```
01 Doc:     Also sometimes when ladies are pregnant is helps?
02          .hh If they eat small little meals through the day
03          instead of one big one.
04 Pat:     Mm-hm yeah,
05          (0.4)  ((Doc nodding))
06 Doc:     And did they give you the sweet drink to drink
07          or not this time?
08 Pat:     Yeah, they did.
09 Doc:     Today?
10 Pat:     (Na[h? th-)
11 Doc:        [In the very beginning.
12 Pat:     In the very beginning, yeah.
13 Doc:  -> So we'll repeat that when you come back in next
14       -> time. Is that ar[right?]
15 Pat:                     [Okay, ] yeah,
```

At the end of the visit, the doctor wraps up a discussion of controlling nausea through strategic eating. After the patient registers her understanding at line 4, the doctor inquires in line 6-7 if the patient had "the sweet drink to drink" when she arrived at the clinic. This is a reference to blood glucose testing, which is performed an hour after the patient drinks a sugary drink. The "And-" preface the doctor uses here, similar to the "so" preface in the previous example, serves to routinize the utterance, although in a different way. While "so" portrays the utterance as triggered by something in the previous talk, "and" portrays the utterance as driven by routine standard of care, part of schedule, and unconnected to the previous talk (Heritage and Sorjonen 2009).

After the patient confirms that she did receive the drink (which means that she will have her blood drawn after this visit), the doctor announces that they will repeat that test at the patient's next visit, with a "so"-prefaced pronouncement in lines 13-14. At this point it is clear that the doctor's question in lines 6-7 was a pre (Barnes 2018) to introducing the idea of performing the test again at the next visit, as having done the test once will make it not a big deal for the patient to do it again, and renders further explanation unnecessary. The doctor, then, can build her introduction using a more authoritative pronouncement format (Stivers et al. 2018), although she does add "Is that [all right]" in line 14 just to be sure the patient is on board. The patient agrees in overlap in line 15 with "Okay" and adds "yeah" to confirm that it is ok.

In the next example, the doctor announces a plan to draw a blood test to screen for birth defects[7] at the end of the visit, after the ultrasound:

Excerpt 5.3

```
019-01 (17 wks), companion present, return patient
Patient seated on table, companion in chair, Doc seated on stool
Gravida 1, Para 0
13:46
01 Pat:     Would I have to make an appointment or just walk in.
02 Doc:     You need to make an appointment.
03 Pat:     Alright.=  ((head nod))
04 Doc:     Okay? Come on 'en, (("then"?))  ((hand gesture))
05          (2.6)   ((all rise, Doc grabs ultrasound printouts))
06 Doc:  -> And we're gonna draw one blood test for birth
07       -> defects today,
08          (0.6)   ((Doc tearing ultrasound pictures apart))
09 Doc:  -> Ah:m becau:se you are eighteen weeks so that's
10       -> the time to check for Down Syndrome.
11 Pat:     Okay. ((gathering things, doc tearing US picture))
12 Doc:     And I'm gonna give you this little note, which
13          has your measurements for your baby on it? And the
14          due dates,
```

At the end of the visit, after the ultrasound, the doctor has just instructed the patient to return to the clinic in one week so the doctor can check her blood sugar levels (this patient has type 1 diabetes) and clarified that she must make an appointment for that. Then she moves to end

[7]As noted in Chapter 1: 1) These are screening tests, conducted in the first and second trimester, and are not diagnostic., and 2) the state of California mandates the offering of prenatal screening for birth defects.

the visit by inviting the patient and her friend to rise in line 4. As the patient and her friend stand up and gather their things, the doctor mentions a plan to initiate a screening test for birth defects in line 6. She starts with an and-preface, again suggesting a next-on-list quality (Heritage and Sorjonen 2009). "We're gonna draw" is pronouncement format (Stivers et al. 2018), presupposing that it will happen. "One blood test for birth defects today" suggests that this is not the only time that this particular blood draw will happen. Unlike the previous cases, where the motivation for the activity (checking for problematic conditions) is not referenced directly, here her formulation of the test ("blood test for birth defects") does indicate explicitly the (highly) problematic conditions she will be checking the potential for. However, she has already registered the activity as routine with the "And" preface, and she will continue by adding justification that further normalizes the activity in lines 9-10. (The patient, still collecting herself, has so far not reacted to any of this.) "Because you are eighteen weeks" invokes a standard of care that exists outside this doctor's particular practice, in which the timing of the test is determined by fetal age, based on the medical profession's best knowledge. This is further reinforced by "so that's the time." Her reference to checking for Down Syndrome, a commonly known genetic condition that results in developmental delays, downgrades the purpose of the test – it will actually screen for spinal cord defects and other serious developmental delays as well. Thus, although the doctor does explicitly mention potentially worry-inducing conditions, her routinization of the test portrays it as emerging from a standard schedule of care and not anything particular to this patient. The patient agrees to this plan with final-intoned "Okay" in line 11, and the doctor moves on to giving her a picture from the ultrasound (which, it should be noted, was normal – so the patient has already received some reassurance that her baby is developing just fine).

To further illustrate just how common and-prefacing is in particular, here are two more examples of the doctor using an "And" to introduce testing or procedures:

Excerpt 5.4

```
018-01 (11 wks), no companion, return pt
pt seated on table, doc at counter with chart
Gravida 1, Para 0
4:06
01 Pat:     Yeah:. I'll be like twenty eight,
02 Doc:     Yeah.
03          (0.6) ((Patient looking at IUD model))
04 Pat:     Okay,
05          (0.6) ((Patient hands model back to Doc))
06 Pat:     All right,
07 Doc:     So I'll give you some stuff to read,
08 Pat:     Mm:?
09 Doc:  -> And then let's take a listen to the heartbeat?
10 Pat:     Ohkay.
11 Doc:  -> An::d,
12          (0.8) ((Doc writing in chart))
13 Doc:  -> We're gonna draw the b- first blood test for birth
14       -> defects if that's ok[ay. (             )]
15 Pat:                         [Oka]y. And it's jus]t blood
16          testing right?
```

Excerpt 5.5

```
001-03 (11 wks), no companion, return pt
Patient lying on table, Doc at table performing ultrasound
Gravida 3, Para 2
9:18
01 Doc:     Wanna picture?
02 Pat:     Hh Ah-huh? ((smiles))
03 Doc:     (1.0) ((Doc captures image on screen))
04 Doc:  -> Okay. .hh And let's-
05          (1.0) ((Doc reaches for light))
06 Doc:  -> Draw the blood test for birth defects.Is that
07       -> all right?
08 Pat:     N:that's fine. ((nod))
```

In each of these, as in the previous "And-" prefaced cases, the introduction follows previous unproblematic talk and brings off the test or procedure the doctor is introducing next via pronouncement or proposal as similarly unproblematic[8].

IN-PROCESS: POSITIVE COMMENTARY

[8] Although the doctor's addition of apparently permission-seeking phrases after birth defects screening in these cases ("if that's okay" / "Is that all right?") may appear to suggest that the screening is other than routine, their sequential position, appended to an otherwise routine pronouncement and proposal, suggests that they are pro forma afterthoughts. Also, such an afterthought was also seen earlier in 015-01 with repeating blood glucose testing.

During fetal heartbeat detection, the doctor frequently offers some version of the declaration "The baby sounds good." This happens when the doctor has no reason to wonder about anything else – nothing possibly concerning has arisen, and the patient has not asked any questions that might be answered with heartbeat detection. The commentary serves to provide the patient with incremental evidence, along with other evidence that surfaces during the visit, that her baby is okay (Heritage and Stivers 1999). An example of this simple, general assessment of heartbeat is seen below:

Excerpt 5.6

```
008-01 (30 wks), no companion, return patient
Patient laying on table, Doc at table with Doppler
Gravida 4, Para 2
2:26
01          ((Doc places wand on belly))
02          (5.6) ((Listening to heartbeat))
03 Doc:  -> Baby sounds great!
04 Pat:     °Okay,°
05          (0.8)
06 Doc:     Hear?
07 Pat:     M-hm,
08          (1.6)
09          ((Doc removes wand from belly))
10          (14.2) ((Doc wipes belly and Doppler, moves to counter))
11 Doc:     And I have a note here: to offer you the
12          breastfeeding class,
```

Once the doctor places the wand on the patient's belly, the heartbeat is clearly audible (unsurprising given that this patient is in her third trimester). After listening for several seconds, the doctor positively, enthusiastically assesses the heartbeat in line 3 with "Baby sounds great!" The patient responds as though she were merely receiving information with "Okay" in line 4. The doctor treats this apparent information receipt as an indication that perhaps the patient cannot actually hear the heartbeat, and checks this in line 6 with "Hear?" The patient responds with minimally affirmative "M-hm," and the doctor ends the detection shortly after. Both the doctor's quick and positive assessment of the heartbeat and the patient's response with

acknowledgment rather than excitement or relief are typical of the heartbeat detection procedures in this sample.

In 009-01, an unusual case, the doctor not only positively assesses the heartbeat, but also adds to and upgrades her assessment as she receives no verbal response from the patient.

Excerpt 5.7

009-01 (27 wks), no companion, return patient
Patient laying on table, Doc at table prepping Doppler with gel
Gravida 3, Para 1
4:09

```
01 Doc:     .hh Remind me did you breastfeed your first one?
02 Pat:     I did, for a couple months.
03 Doc:     Okay. Do you wanna go to breastfeeding class this time?
04 Pat:     Oh-ah: no,
05 Doc:     No?
06          (6.0) ((Doc places wand on belly, doc moves it around))
07 Doc:     Somewhere here,
08          (15.0) ((Doc searches for heartbeat, finds it))
09 Doc:     There it is.
10          (1.6) ((Patient slowly smiles))
11 Doc:  -> Sounds good.
12          (5.2) ((Patient continues to smile))
13 Doc:  -> Which is good, ((removes wand))
14          (1.0) ((Doc to counter, grabs paper towel))
15 Doc:  -> Very good,
16          (1.0)  ((Doc to table, wipes off belly))
17 Doc:     Arright, so we would normally see you back in a
18          month at this point is that all right?
19 Pat:     °M-hm,°  ((nods))
```

Although the doctor initially has trouble locating the heartbeat, she finally finds it, and notes it by stating "There it is" in line 9, as the heartbeat becomes audible on the device. The patient utters no verbal reaction, but does smile and continues to smile as they keep listening. The doctor quickly assesses what she hears with "Sounds good" with period intonation in line 11. The patient still says nothing but continues to smile. The doctor then adds a general positive assessment of the positive assessment of the heartbeat, "Which is good" in line 13. The patient, again, says nothing but continues to smile. The doctor then upgrades her general assessment with "Very good" in line 15. The patient still says nothing. This excess of positive commentary is perhaps the result of the patient's lack of uptake or response, not only here during the heartbeat

detection, but during the rest of the visit leading up to this point. Almost ready to close the visit, the doctor appears to be pursuing response to make sure the patient knows her baby is fine.

007-01 is also a somewhat unusual case, but this is due to the patient's response instead of the doctor's comments. Here we see the patient deliver more than minimal response to a typical heartbeat assessment:

Excerpt 5.8

007-01 (27 wks), companion present, return patient
Patient laying on table, companion in chair, Doc at table with Doppler
Gravida 1, Para 0
15:39
01 Doc: Let's listen to the baby, ((wand on belly))
02 (2.0) ((heartbeat audible))
03 Doc: -> Baby sounds good,
04 Pat: -> Very good. That's why I'm like,=I'm not scared
05 -> about the [b]aby?
06 [*] ((Doc removes wand from belly))
07 Com: I[n the hospital s]he was like,
08 Pat: -> [For the fever?]
09 Com: I[t was pretty low.
10 Pat: -> [It just:
11 -> It was very low bu:t, ((places hands on belly))
12 (0.4) ((Doc wiping off belly))
13 Pat: -> I: I told 'em I was like it's yer: it's yer
14 -> little [thing. ((gesturing with hands over belly))
15 Doc: [Thing is in the wrong place.
16 Pat: Yes.

This patient has come into clinic extremely dissatisfied with the care she received from the nurse midwife at her previous visit. She has not been feeling well for a while, and she and her mother (who is also present) feel that the nurse midwife should have prescribed something last time due to the fever she was feeling. In the meantime, she visited an ER, who gave her antibiotics for a presumed bladder infection. So this patient has perhaps more reason than most to be concerned. Well over ten minutes into a tense discussion (in which the doctor firmly defends the nurse midwife's failure to prescribe, citing the negative urine test results at that visit), the doctor initiates measuring and heartbeat detection while discussion of the patient's alleged infection continues. After the doctor delivers her usual positive assessment of the heartbeat in

line 3, the patient upgrades the assessment to "Very good" in line 4, in itself an unusual move as she does not have the epistemic authority to determine if what she is hearing sounds "good" or not (Heritage 2012), and then adds that the very good heartbeat is why she is "not scared about the baby" because of the fever in lines 4-5 and 8. Up until now, she has not mentioned concern about the baby's health in light of her own illness, but here she emphatically and explicitly rejects the idea that she is scared for her baby, just in case there was any question. Her reason for doing so starts to become evident starting in line 7 and 9 as her mother starts to explain that, while in the hospital, the heartbeat was "low" when listened to. The patient confirms that it was "low" but blames that on erroneous placement of the wand (the "thing" she articulates with her hands while speaking) in lines 13-14.

In the few cases where the doctor does not vocalize positive assessment of the heartbeat, it is because she is providing commentary relevant to a possible concern or question that has come up earlier in the visit. For example, in 024-01, the doctor notes that the patient had been breech at the last visit, and then when detecting heartbeat, comments on fetal positioning instead of providing general assessment:

Excerpt 5.9

024-01 (32 wks), companion present, return pt
Patient seated on table, companion in chair, Doc at counter with chart
Gravida 3, Para 1
0:54
01 Doc: Okay. I'm looking to see what-tah testing she had
02 done before, .hh a::nd,
03 (8.0) ((Doc paging through chart))
04 Doc: You had been breech when you'd had your last
05 ultrasound did you want us to check and see if the baby's
06 still upside down?
07 (0.5) ((Doc still looking down at chart))
08 Doc: Or if it's flipped around?
09 Pat: Yeah.
10 Doc: Okay we can do that real quick, ((looks to companion))
11 ((63 seconds - Doc measures, discussing movement, grabs Doppler))
12 ((Doppler starts))
13 (1.4)
14 Doc: There's-
15 (0.8) ((listening))

```
16 Doc:  -> Yeah I think you're right cause if you're feeling
17       -> pressure up here it's probably kicking you up
18       -> there, .hh I'm hearing the heartbeat (.3) below
19       -> the belly button,
20          (0.8) ((doc looks down at doppler))
21 Com:     Hm-hm-hm! ((chuckling))
22          (0.6)
23   ((Doppler ends, doc to paper towel))
24 Doc:     And let's look and see where the head is,
25 Pat:     °Nnhey°,  ((mumbled "okay"))
```

Although the doctor implied she would "check" the baby's position via ultrasound (in line 5, and in omitted lines), while listening to the heartbeat, she chooses to comment on where she is hearing the heartbeat (lines 18-19) rather than how what she is hearing sounds. The patient had guessed that the baby had "flipped around," and mentioned that she could feel pressure below her ribcage. The doctor states she thinks the patient's guess is probably right and speculates that the pressure felt was the baby kicking in lines 16-18. She then adds commentary on what she is hearing in the moment, "I'm hearing the heartbeat below the belly button." Taken by itself, this matter of fact statement would not necessarily indicate anything to the patient regarding the health or safety of her fetus. But in this context, it suggests that the baby has "flipped around" since the last visit, which is a good thing. Although the baby's father chuckles during the listening, the patient herself does not react at all to the heartbeat or the implication that the baby has achieved correct position for delivery.

In the case of measurement, the doctor often does not offer any commentary at all, saving her assessment for after measurement is completed (which I will note in the next section). Measurement often happens while the doctor and patient are discussing something else, or nothing at all. In the few cases where the doctor does offer commentary on what she is seeing and feeling, it is a comment on how far the baby extends into the abdomen, like in example 016-01:

Excerpt 5.10
016-01 (37 wks), companion present, return patient

```
Patient lying on table, companion in chair, Doc at table
Gravida 2, Para 1
10:33
01  ((measuring starts))
02 Doc:     And we'll be seeing you once a week f[rom now on.
03 Pat:                                          [Okay.
04          (0.8)  ((Doc pulling tape measure taut))
05 Doc:     My hands are cold I'm sorry,
06          (1.6) ((palpating with top hand, pulling tape again))
07 Doc:  -> Baby up to he:re, Do you have any questions sir?
08 Com:     No.
09 Doc:     No,
10          (1.2)
11  ((removes tape from belly, moves toward counter))
```

As seen here, the only commentary the doctor provides regarding what she is seeing or feeling is "baby up to here" in line 7, which she says as she pulls the tape measure taut after having palpated the patient's upper abdomen with her left hand. This statement by itself does not provide an assessment of the baby's condition. The doctor then immediately solicits questions from the patient's partner, with a negatively polarized interrogative that anticipates a no-problem answer, and thus retroactively treats her prior utterance as unproblematic.

POST-HOC: REVIEWING RESULTS

Often after procedures and always after testing (once results are in hand), the doctor comments on the results with what Maynard has identified as "auspicious interpretation" (Maynard 2006), highlighting the positive aspect and thus indicating to the patient that her results are normal or not concerning. The patients, as in the previously discussed stages, typically respond with acknowledgement rather than relief.

When the doctor has results of previous blood or urine testing, she always reviews them with the patient. Sometimes she provides only a simple assessment of the results, as in 010-01:

Excerpt 5.11

```
010-01 (27 wks), companion present, return pt
Patient seated on table, companion in chair, Doc at counter with chart
Gravida 1, Para 0
8:34
```

```
01 Doc:     We shall see:,  ((Doc's back to patient))
02          (1.8) ((Patient looking at printout))
03 Pat:     °Oh:kay:,°
04          (5.0)  ((Patient looking at doc and then to the door))
05 Doc:  -> And your urine looks fine, ((Patient looks at doc))
06          (0.8)  ((Patient looks back down at printout))
07 Doc:     Um did you- wanna get thee: vaccine for the
08          whooping cough? We r[ecommend it fo]r everybody.
```

Just before the doctor will wrap up the visit, she stands at the counter, with her back to the patient, writing in the chart. At the start of this excerpt, she and the patient are discussing the limits of confidence in due dates estimated by ultrasound, prompted by the ultrasound that has just been performed. The patient is holding a printed picture from the ultrasound and looking at it. While writing in the chart, the doctor comments on the results of the urine test performed when the patient arrived in the clinic in line 5. She offers no specifics, simply "affirming the positive" (Maynard 2006) that the patient's urine "looks fine," which actually means the results are within normal range. The patient does not respond to this, and the doctor moves on to discussing the pertussis vaccine in line 7.

Sometimes, when reviewing results, the doctor will show the patient the actual result in the chart, as seen in 006-02:

Excerpt 5.12

```
006-02 (11 wks), companion present, return pt
Patient seated on table, companion in chair, Doc at counter with chart
Gravida 1, Para 0
2:12
01 Doc:     >That's how you found out you were pregnant right
02          they brought you in to [the emergency room?
03 Pat:                            [Yeah,
04 Doc:     .hh And I wanted to go over the lab work we did
05          last time it's all good,
06 Pat:     Mm:kay,
07       -> (1.6) ((Doc to patient with chart))
08 Doc:     So your blood count is thirty six percent,=which is
09          fine no anemia you don't need any extra iron,
10 Pat:  -> [Mm,] ((Doc showing patient each result in chart))
11 Doc:     [.hh] Your blood type just for your own information
12          is A positive? Which is fine the test for hepatitis,
13          the test for: um: the German measles, .hh all show
14          that there's no risk of your baby getting those, .hh
15       -> um, an:d then:, ((Doc flipping through chart, pointing))
16          the sugar test, the test for diabetes was negative
```

```
17          at eighty nine which is very good, .hh gonorrhea
18          and chlamydia were negative as well and the test for
19          HIV was negative. ((Doc looks at patient))
20 Pat:     [ Mm - hm,]
21 Doc:     [And there]'s no bladder infection. .hh  ((to counter))
22          So that's what we tested last time this time with
23          your permission we're gonna draw a blood test that
24          looks for birth defects in the baby.
25 Pat:     Mkay, ((nod))
```

The doctor announces her intention to "go over" the previous lab work in line 4 and immediately adds a summative positive assessment, "it's all good" in line 5. The patient gives minimal assent in line 5, and the doctor approaches the patient with the chart and points out to her all the results as she covers them in rapid fire in lines 8-21. She reports the exact blood count number, plus positive assessment "fine," and positive consequence "you don't need any extra iron" in lines 8-9. Then comes blood type, which as she notes is not a test result per se, she's just informing the patient for her own information – yet she adds an assessment of "fine" there too (lines 11-12). Hepatitis and German measles are lumped together and the results characterized more specifically, noting "no risk of your baby getting those" (lines 12-14). The diabetes test, worded first as "the sugar test" and then re-worded as "the test for diabetes," gets a general result ("negative"), specific result ("at 89"), and positive assessment "very good" (lines 16-17). Gonorrhea and chlamydia get lumped together as well, with results characterized as "negative" (lines 17-18), and HIV is stated as "negative" as well (line 19) – the negative results of these sexually transmitted diseases are presumably readily recognizable as a good thing, and need no further specification. (And by this point a pattern has become evident: results that are hearably good – "negative," "no bladder infection," etc. – need no further assessment, whereas results that are not obviously good news – "36 percent," "eighty-nine," etc., are followed with commentary to clarify that it's good news.) Looking to the patient, the doctor adds one more – "no bladder infection" (line 21), an example of "disconfirming the negative" (Maynard 2006). The patient

offers no response to the quickly delivered reporting, simply following along in the chart as the doc points to all the results. She does respond when the doctor looks at her in line 19, only to offer a simple "M-hm" in line 20.

The doctor may also bolster report and assessment of normal results with reference to specific medical knowledge, similar to the radiation experts in Nishizaka's study of post-disaster Fukushima (Nishizaka 2017). In 016-01, after the patient inquires about the results of her previous diabetes test (which patients sometimes do), the doctor includes the specific medical rationale behind her assessment of the results:

Excerpt 5.13

```
016-01 (37 wks), companion present, return patient
Patient seated on table, companion in chair, Doc entering room
Gravida 2, Para 1
0:06
01 Doc:     .hh Uhm any questions or pr[oblems?]
02 Pat:                                [ . h h ] Yes um
03          I had as:- a: sugar test in: March I believe.
04 Doc:     Uh-h[uh,  ((Doc sets chart on counter and looks into it))
05 Pat:         [Ah: and I never really got the results for
06          that. [(I just wondered as:)]
07 Doc:           [Well  let's  take a p]eek.
08          (1.0)  ((Doc turns page in chart and looks))
09 Doc:     .h So your sugar test from March fourth was
10          normal. .h[h And tha]t's a screening=
11 Pat:               [Mm -  hm,]
12 Doc:     =test for sugar diabetes,
13 Pat:     Uh-huh,
14 Doc:  -> An:d we consider anything: a hundred and
15       -> forty or less to be normal,
16 Pat:     Okay,
17 Doc:     And yours was one hundred.
18 Pat      O[h:
19 Doc:      [So very normal. ((approaches patient with chart))
20 Pat:     Okay.
```

The doctor begins this visit by asking the patient if she has any questions immediately after greeting her. The patient is ready with her question, taking an inbreath before the doctor finishes her question, and coming in as soon as the doctor's question is complete, in line 2. The patient gives a declarative statement, stating that she had a sugar test at a previous visit. Given that she began speaking when prompted for questions, this could be hearable as a question

regarding her sugar test in March. The doctor passes on verbally responding to the statement as a question, although she does set the chart down and begin to look into it. The patient continues with a second assertion – she never got the results (lines 5-6). Now the doctor treats her statement as a request, and proposes "taking a peek" in line 7. Remaining at the counter, the doctor then reports the results, first with a broad characterization of "normal" in lines 9-10. She then explains that the sugar test is for diabetes in lines 10-12. Then in lines 14-15, she references specific medical criteria, stating the range that "we" (meaning the profession) consider normal, and noting the patient's exact score. She then adds an upgraded, if slightly nonsensical, assessment, "very normal," in line 19. The patient responds throughout with continuers until the doctor makes the connection between her scores and the specific range of normal, at which point she delivers an "Oh" to register receiving new information (Heritage 1984a).

In the case of measuring, as I mentioned briefly in the previous section, the doctor saves her positive assessment of results until after she is done measuring. She typically announces her findings as she walks to the chart to record them, as seen in 017-01:

Excerpt 5.14

```
017-01 (28 wks), no companion, return patient
Patient
Gravida 2, Para 1
7:23
01 Doc:     But usually we just try to do it with the Monistat
02 ((tape measure to belly))
03 Doc:     and avoid the pills while you're pregnant.
04          (1.6)
05 Doc:     Little pressure here.
06          (3.0)
07 ((tape measure off belly, doc moves to counter))
08 Doc:  -> And your belly measures twenty eight centimeters
09          which is perfect for twenty eight weeks,
10       -> (0.8) ((moves light, walks to chart))
11 Doc:     And let's listen to the heartbeat,
```

In this typical case, the doctor continues with ongoing discussion (here regarding treatment for the patient's current yeast infection) as she begins to measure. She offers no

commentary during the measurement, but does warn the patient that she will feel pressure when she presses into the belly with the tape (line 5). Once she removes the tape from the patient's belly, she announces her findings as she walks back to the chart to record them. She states the exact measurement "twenty-eight centimeters" (line 8), and then adds a positive assessment relating the patient's current belly size to what would be expected at this gestational age, "perfect for twenty-eight weeks" (line 9). The patient does not respond, and the doctor moves on.

It should be noted that results are not always "fine," "perfect," "normal," etc. Although none of my recordings captured objectively unfavorable results, there were a couple instances where results were ambiguous or unexpected. When that occurs, the doctor still has opportunity to assuage potential worry.

One way to do this is to simply minimize the unexpected result. In 008-01, the doctor finds that the baby measures larger than expected by fetal age:

Excerpt 5.15

008-01 (30 wks), no companion, return patient
Patient laying on table, Doc performing measurement
Gravida 4, Para 2
1:56

```
01          (2.0) ((Doc palpating tummy))
02 Doc:     Ah you got baby up to there.  ((measuring))
03          (1.0)  ((measuring))
04 Pat:     Ooh, That hurt.
05 Doc:     'm sorry!
06 Pat:     That's ok-heh-heh!  ((Doc removes tape measure))
07          (0.4) ((Doc moves to counter))
08 Doc:  -> So I get thirty-f:our centimeters which is:
09       -> (0.4) bigger than last time and a little bit bigger
10       -> than your dates,
11          (0.6)
12          Doc Let's listen to the baby's heartbeat,
13          (3.8) ((Doc moves to table, preps Doppler))
14 Doc:     You're still working, right?
25 Pat:     No.
```

As usual, the doctor offers no commentary on what she is seeing or feeling until she is finished measuring. As she walks back to the counter to record her measurements, she states the exact result, thirty-four centimeters (line 8) and adds that it is "bigger than last time." Bigger

than last time is not concerning – one would expect that the baby would have grown since the last visit. But the measurement is larger than expected – after 20 weeks gestation, fundal height in centimeters is expected to match the number of weeks, so at 30 weeks, the doctor would expect to find a fundal height of 30 centimeters. However, she does not explain this, and instead merely characterizes the finding as "a little bit bigger than your dates," with emphasis on minimizing descriptor "little" (lines 9-10). The patient gives no response, and the doctor moves on quickly to heartbeat detection.

Another option the doctor has in the face of unexpected results is to try something else. When patient 008 returns for her next visit (labeled in my sample as 008-02), her baby again measures large via tape measure. This time, in addition to using minimizing descriptions, the doctor chooses to investigate further, first by measuring again, then resorting to ultrasound for a more accurate measurement:

Excerpt 5.16

008-02 (34 wks), no companion, return pt
Patient seated on table, Doctor at table measuring belly
Gravida 4, Para 2
1:27

```
001 Doc:     Nothing regular? No pattern?
002          (0.2)  ((doc palpating belly still holding tape))
003 Doc:     My hand's up here. ((left hand on upper belly))
004          (2.0)  ((doc still feeling upper belly)
005 Doc:     So there's a big ball up there,
006          (2.4)  ((doc digs into lower belly with right hand))
007 Doc:     And there's a: (.) a smaller hard ball down here,
008 Pat:     Okay.eh-heh!
009 Doc:     So I think it's already head down?
010          (1.6)  ((doc feeling all over belly with left hand))
011 Doc:     Like I said we can do the ultrasound today but- (.)
012          but usually it doesn't actually matter what it
013          is today?[=It's more im]portant what it is
014 Pat:              [ M m  -  h m,]
015 Doc:     in two weeks.
016 Pat:     Okay.
017          (1.0)  ((doc securing tape over belly)
018 Doc:     And I can put a note that we'll do an ultrasound
019          in two weeks.
020 Pat:     O[kay.]
021 Doc:      [When], (0.2) you come back. .hhh ((walks to chart))
022       -> And I get-hhh a little bit a big on the size, you
023       -> feelin like this baby i:s bigger than your others?
```

```
024 Pat:     eYeah I feel a little lot more heavier. eh-HEH!=
025 Doc:     =You fe[el  heavier.]
026 Pat:            [ heh-heh-heh]-Ye(heh)s,
027 Doc:  -> Well then let's do the ultrasound today and (.) see
028       -> how big it is.
029 Pat:     Okay, h[eh!
030 Doc:            [As well as which
031          direction it is.[>='n let's listen]=
032 Pat:                    [ v O  k  a  y  . ]
033 Doc:     =to the heartbeat cuz-< .hhh I got a slightly large:
034          measurement last time, [o:r, tch]-ah:, actually
035 Pat:                           [Mm - hm,]
036 Doc:     Sarah did. .hh She got four centimeters ahead, and
037          I'm getting about five centimeters ahead I got
038          thirty ni:ne, [at thirty four weeks] so .hhh either
039 Pat:                   [tch O h    o k a y ,]
040 Doc:     we're way off on your dates? ((feeling belly for HB))
041 Pat:     Okay?
042 Doc:     Or::, we're measuring funny, ((doppler noise))
043 Pat:     Hm,  ((dopper noise))
044 Doc:     Or the baby's big. So l[et's see which one it is.
045 Pat:                           [Okay.
046  ((1 minute, 44 seconds — continue discussing fetal position,))
047  ((doc leaves to retrieve ultrasound machine,))
048  ((comes back without it and sits on stool at counter, in chart,))
049  ((pt still lying on table))
050 Doc:     Now you're dated by a very early ultrasound the one
051          we did in December. So::, .hh the dates are not off:,
052          (0.7)
053 Doc:     U:m:, you've gained m:ore than we would recommend
054          but not a crazy amount more.
055          (0.5)
056 Doc:     You know thirty: th-two pounds?
057          (0.4)
058 Pat:     °Okay,°=
059 Doc:     =°An::d,° at thirty four weeks,
060          (12.0) ((Doc still in chart, pt lies on table silent))
061 Pat:     Hope he's not too big, eh-huh!
062 Doc:     Yeah I ho[pe he's not too [big  al]so.
063 Pat:              [ .  h  h  h     [eh-huh!]
064          (5.8)  ((Doc still in chart))
065 Doc:     'n yer sugar tests were all normal.
066 Pat:     Okay that's good.=
067 Doc:     =So::, I think it's just probably the way you measure?
068 Pat:     Mm-hm,
069          (2.8)  ((Doc finishes in chart and starts to rise))
070 Doc:  -> We can try it with you lying down flat see if we c'n
071       -> get a:: more accurate (.) number, if I'm careful
072       -> about technique.
073       -> (0.2)  ((doc lowering table back with pt still on table))
074 Doc:  -> (Lowering you) all:: the way down flat.=Sorry bout that.
075          (1.5)  ((doc walks to counter for tape measure))
076 Doc:     See what we get.
077          (3.0)  ((doc approaches pt and begins measuring))
078 Doc:     But you think the baby's bigger than your others.
079 Pat:     U:m I just feel heavy,
080 Doc:     You feel heavy. ((nods, feeling upper belly with L hand))
081          (0.3)
```

```
082 Doc:     Heavier than you did bef[ore?]
083 Pat:                             [Yeah].
084          (1.5) ((Doc feels baby with L hand, holding tape with R))
085 Doc:     Yeah I mean you definitely got baby all the way
086          up tuh here. So::,
087          (5.2) ((Doc measuring))
088 Doc:     °Ri::ght he:re,°  ((barely audible whisper))
089       -> So with you laying flat,
090 Pat:     M-hm, ((doc moves to chart on counter))
091 Doc:  -> I still get d'I still get more than: (0.4) I should
092       -> for the gestation. I got- still got thirty nine.
093          (0.4) ((doc sits in stool))
094 Doc:  -> .hh So, let's see what the ultrasound shows maybe
095       -> there's a lot of water in there or somethin',
096 Pat:     Okay.  ((stil lying down))
097          (1.0) ((doc steps stool closer to patient))
098 Doc:     And no test is a hundred percent accurate.
099 Pat:     Right,
100 Doc:     I mean, as long as you're feeling the baby move
101          regularly?
102 Pat:     M-hm,
103 Doc:     You're good.
104 Pat:     Okay.
```

This patient has asked the doctor at the beginning of the visit to "measure" fetal position because she was wondering if the baby was head down yet or not. The doctor has agreed to measure, and stated that she could do an ultrasound if the patient absolutely wanted to know positioning. At line 18 she demonstrates that she's not very committed to performing an ultrasound today, announcing that she will put a note in the chart to have one done at the next visit in two weeks. Meanwhile, she has started measuring – and she finds the measurement to be larger than expected. Instead of stating the exact measurement, she says she gets "a little bit big on the size," again mitigating like in the previous example. After confirming that the patient feels heavier in this pregnancy than in her previous one, the doctor decides to do the ultrasound in lines 27-28. The doctor then notes the large measurements from the previous visit in lines 33-36 and the one she has just now found in lines 37-38, adding specificity by saying that she got "five centimeters ahead" and "thirty-nine." Given the implication that the due date is possibly quite wrong (line 40), the doctor demonstrates determination to get to the bottom of the unexpected measurement. She leaves the exam room to retrieve the ultrasound machine, but it is in use, so

she returns empty-handed. While waiting for the machine to be delivered by staff, she rules out excessive weight gain and gestational diabetes as explanations in lines 53-65, and decides to measure again, this time with the patient lying completely flat on her back. She measures, and announces in line 91 that she still gets 39 centimeters, and resolves again to see what the ultrasound shows. (It will show expected size for the gestational age of 34 weeks, and the doctor will then declare that "It's all good.")

DISCUSSION

In examining the introduction, implementation, and post-hoc review of routine testing and procedures, we can see how these activities are produced in a matter of course way, with minimal patient reaction, often bolstered by medical knowledge or positive commentary, sometimes even with explicit rejection of the idea of worry. Every activity within prenatal care could be a source of worry, and these features enable the doctor and patient to circumvent potential concern in prenatal visits. This allows for a "worry-light" environment where the patient can become informed and the doctor can monitor the patient for potentially harmful conditions without causing the patient to become alarmed. This may be most striking in the case of birth defects screening.

Birth defects screening offers more potential for worry than other routine blood testing, fundal measurement, or heartbeat detection, yet we still see the same routinizing strategies as are found in other tests and procedures. And the only cases where patients offer more than minimal response are birth defects screening cases – yet the majority of the time, patient responses are minimal even for these screenings. It may be the case that these "worry-light" promoting features have a herd effect, wherein potentially more worrisome procedures are made to appear less worrisome by virtue of their interactional resemblance to procedures with markedly lower stakes

(see again the introduction of birth defects screening quickly following the introduction of heartbeat detection in 018-01). Indeed, research by Press and Browner (Press and Browner 1997) on pregnant women's rationale for accepting birth defects screening demonstrates how institutional treatment of the screening shapes women's views of it as "just another test" – with even initially reluctant patients agreeing to the screening in the moment because, as they report, "routine takes over." This chapter, then, appears to identify some of the specific interactional practices behind the routinization of all prenatal care procedures – including those that are potentially more worrisome than others.

This work builds on previous CA work relevant to worry in two interesting ways. First, it offers a complement to Nishizaka's work on problem presentation within prenatal care (Nishizaka 2011b) by examining instances when the patient does *not* bring up specific problems – rather, when she participates in the routine activities of any normal prenatal visit. In the absence of specific concerns, it appears here that there may be a preference for obscuring worry rather than exposing (and perhaps subsequently addressing) it. Second, it contains may instances of Maynard's "auspicious interpretation" (Maynard 2006), but without the corresponding patient alignment and agreement that appeared to be normative in his study. Here, patients barely respond at all to positive assessments and interpretations of their physical findings or test results. This may be further evidence of the utter mundanity of the activities examined in this study.

Chapter 6. Discussion and Conclusions

The analytic work in this dissertation builds on previous CA work in medical settings by highlighting various conversational practices within prenatal care that have consequences for visit trajectory and activity, future decision making, and routinization of visit components. In chapter 3, we saw how the doctor and her patients index a secondary orientation to the ultrasound as a valid means to satisfy patient curiosity, while simultaneously maintaining a primary orientation to the ultrasound as a medical tool. In addition, both parties may exploit patient curiosity as a cover for medical concerns. Chapter 4 investigated how introduction of different points of future decision implicate varying levels of patient agency in determining the course of care. These differing levels of agency appear to vary systematically with the type of decision under discussion. In chapter 5, we saw how the doctor and patients' regular use of particular interactional strategies creates an environment in which worry is obscured or circumvented. This allows for the doctor to monitor the patient and share information with her without triggering alarm.

Taken together, these chapters help to elucidate how important prenatal care objectives are pursued with due sensitivity to patient interests and concerns. In introducing ultrasounds, the doctor monitors the patient for potentially harmful conditions while also providing the patient with reassurance and a moment to bond with her baby. In shaping future decisions, she steers the patient toward courses of action while allowing for varying levels of interest and knowledge. In doing the bulk of the work behind the "worry light" environment, she reassures the patient through information and normalizes the activities to assuage potential patient worry. In these ways, the doctor successfully balances medical objectives with what Mishler termed "the lifeworld of the patient" (Mishler 1984).

This work also expands on the few existing CA studies within prenatal care by providing a fuller picture of prenatal visit interactions. It complements work on ultrasounds by showing how ultrasounds are referenced in conversation before they are performed and what that says about how the parties view the ultrasound, and sheds some light on the factors that influence the doctor's decision to do one. It also expands on Nishizaka's work on patients raising concerns via response expansion (Nishizaka 2011b) by highlighting how patients participate in decision-relevant discussions and how they contribute to a "worry-light" environment.

In addition, considering the three analytic investigations together reveals two threads running through the above chapters that shed further light on doctors' and pregnant women's goals, and possible directions for future work:

Complexity. If there is one thing that has become clear through examining the data in this project, it is that activities within prenatal care usually do not have discrete boundaries. They often overlap, occur simultaneously, or are segmented – being temporarily suspended and then re-engaged later in the visit (or even at a later visit).

Take, for example, visit 016-01, in which the patient asks about birth control in light of her concern to manage her polycystic ovarian syndrome (described in chapter 4). The question of birth control prompts the doctor to ask about breastfeeding intentions, because which birth control pill the patient will take will depend on whether or not she is breastfeeding. When the patient indicates intention to breastfeed, that prompts the doctor to suggest that the patient talk with the staff at her delivery hospital to "work on" breastfeeding right away – which then reminds her to offer the in-clinic breastfeeding class. This is a striking example of how doctors must manage multiple concerns at the same time, and how one concern can influence or even be

embedded in another. Concerns may bear on each other in ways that are not always as evident as in this case.

Another dimension of complexity is evident in the regular multitasking that occurs in the visits. The doctor frequently performs physical actions while continuing an unrelated ongoing conversation or even starting a new one. This can happen at any point during the visit. The doctor may solicit patient questions or concerns while reading the chart to review past procedures and tests, or she may engage in discussions during fundal measurement or ultrasound that have nothing to do with the examination at hand. And, of course, patients may raise questions at any time, even independent of direct solicitations from the doctor. Handling multiple objectives at once may have consequences for the visit that are not readily evident in this study[9].

Additionally, things that arise during the course of the visit can and do alter the trajectory of the rest of the visit. A nice example of this is seen in 001-03, where the doctor decides to perform an ultrasound (which entails tracking down a machine, because there is not one already in the exam room) after failing to detect the baby's heartbeat via Doppler. Examples like this highlight the on-the-spot, "why that now" nature of the doctor's decision making in conducting the visit.

The complexity of prenatal care interaction underlines the importance of taking a systematic interactional approach and analyzing visit conversation – it is the only way to tease things apart to understand how visits unfold as they do in the moment. Further study could focus on visit flow to add more nuance to my conclusions, by determining how these activities intertwine and teasing out more of the complexity I note here. It could be that multitasking has consequences that have not been illuminated in the present study.

[9] See Nishizaka for discussions of this phenomenon within the specific context of ultrasounds (2014b) and prenatal problem presentation (2011b).

Patient initiative as evidence of goals and desires. Much of this study has focused on the doctor's actions – whether or not she chooses to perform an ultrasound, how she introduces future points of decision, her construction of visit procedures as routine. The agenda for the visit is ultimately up to the doctor. But the patient participates in the visit as well, and as evidenced in the preceding chapters, patients have opportunities to make their own wishes and agendas known.

Each chapter includes patients taking initiative to steer discussion and activity, and these actions provide evidence for the goals patients bring with them into prenatal care visits, as well as their views on what prenatal care means to them. In Chapter 3, we saw that patients do display a right to ask for ultrasounds – although in a heavily mitigated way. The reasons they give reflect their desire to bond with the baby through viewing it (Molander, Alehagen, and Berterö 2010), and in at least one case (028-01) these personal reasons are used to mask general concern for the baby's welfare. Thus, here we see a blend of (visual) information seeking for reassurance, plus regarding prenatal care as a possible opportunity for bonding.

In Chapter 4, patients display not only a right but also a clear expectation to receive birth control after delivery, and treat the prenatal care visit as an appropriate place to arrange for its acquisition, even requesting it before the doctor brings it up. In this way, they pursue medical benefits from prenatal care that extend beyond immediate monitoring of the pregnancy in progress.

In Chapter 5, patients sometimes freely ask for test results if the doctor does not first bring them up (see 016-01). Thus we see not only a willingness to submit themselves for surveillance and screening, but a desire to learn specific information about themselves as it is

determined (in addition to general information about pregnancy and what they should be doing), On top of this, there is an obvious entitlement to pursue that information if it is not volunteered.

On the whole, then, the patients in this study display several goals – social bonding, reassurance, learning of general pregnancy information, learning specifics about themselves, and arranging for care that extends beyond the current pregnancy. This suggests a greater initiative to control their care (or at least, certain aspects of it) than allowed by previous investigations of attitudes toward prenatal care among low-income women (Lazarus 1994). The variation in how they bring these things up also displays varying levels of entitlement (consider low entitlement to ultrasounds versus high entitlement to securing future birth control). This study has just barely scratched the surface of the nuances of patient goals within prenatal care. Further study could do more to elucidate these nuances (and determine how they contribute to the complexities noted above).

In conclusion, this study has provided a glimpse into the moment-by-moment construction of prenatal care in one clinic in Los Angeles. Although results are not generalizable beyond this particular doctor, analyses have shown how interactional choices affect visit activities and shape decision making in this particular setting. The findings could be used as the basis for further quantitative study (Clayman, Elliott, Heritage, and McDonald 2006; Stivers, Enfield, Brown, Englert, Hayashi, Heinemann, Hoymann, Rossano, de Ruiter, Yoon, and Levinson 2009) within prenatal care that both broadens and deepens our understanding of the practices identified here.

APPENDIX

Table A.1. Patient Demographics

Patient ID	Age	Race	Hispanic	Insurance	Gravida	Para
001	32	(not given)	no	private insurance	3	2
002	34	Black	yes	Medicaid	2	1
003	31	Black	yes	Medicaid	2	0
004	27	Filipino	no	Medicaid	3	2
005	31	White	yes	Medicaid	1	0
006	22	Filipino	no	Medicaid	1	0
007	24	Filipino	no	Medicaid	1	0
008	31	Black	yes	Medicaid	4	2
009	(not given)	Black	yes	Medicaid	3	1
010	21	White	no	Medicaid	1	0
012	25	White	yes	Medicaid	2	1
015	18	White	no	Medicaid	1	0
016	26	Filipino	no	Medicaid	2	1
017	25	(not given)	no	Medicaid	2	1
018	18	Filipino	no	Medicaid	1	0
019	18	Filipino	no	Medicaid	1	0
020	31	Black	yes	Medicaid	1	0
021	24	White	no	Medicaid	4	3
022	32	(not given)	no	Medicaid	5	3
023	28	Other Asian	yes	Medicaid	4	1
024	32	Filipino	no	Medicaid	3	1
026	25	Black	yes	Medicaid	1	0
027	38	White	yes	Medicaid	2	1
028	18	Filipino	no	Medicaid	1	0

Table A.2. Visit Characteristics

Visit ID	Length (min)	Gest age (wks)	Trimester	Comp present	Doppler HB	Fundal Height	Ultrasound	New to clinic
001-01	15	4	1	no	no	no	yes	yes
001-02	8.83	8	1	no	no	no	yes	no
001-03	13	11	2	no	yes	no	yes	no
002-02	9.5	36	3	no	yes	yes	yes	no
003-01	8.17	-	1	yes	no	no	yes	no
004-01	6.83	29	2	no	yes	yes	no	no
005-01	13	24	2	no	no	no	yes	no
006-01	14.75	8	1	yes	no	no	yes	yes
006-02	9.75	11	1	yes	no	no	yes	no
007-01	23.45	27	2	yes	yes	yes	no	no
008-01	7.67	30	3	no	yes	yes	no	no
008-02	21.42	34	3	no	yes	yes	yes	no
009-01	6.75	27	2	no	yes	yes	no	no
010-01	9.92	27	2	yes	no	no	yes	no
012-02	18.38	20	2	no	yes	no	yes	no
015-01	12.03	23	2	yes	yes	yes	no	no
016-01	8.25	37	3	yes	yes	yes	no	no
017-01	11.59	27	3	no	yes	yes	no	no
018-01	6.5	11	1	no	yes	no	yes	no
018-02	8.92	15	2	yes	yes	no	no	no
019-01	12.75	17	2	yes	yes	no	yes	no
019-02	8.9	19	2	no	yes	yes	no	no
020-01	13.17	-	1	no	no	no	yes	no
021-01	15.25	18	2	no	no	no	yes	yes
022-01	17.25	22	2	no	no	no	yes	yes
023-01	12.75	6	1	no	no	no	yes	yes
024-01	11.67	32	3	yes	yes	yes	yes	no
026-01	15.5	21	2	no	no	no	yes	yes
027-01	11.13	25	2	no	yes	yes	no	no
028-01	7.67	32	3	no	no	yes	yes	no

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