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Health-Promoting Behaviors or Preventive Health Behaviors:

Patient Disclosures and Physician Lifestyle Advice

in the Primary Care Consultation

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

Clara Ann Blomgren Bergen

2019

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ABSTRACT OF THE DISSERTATION

Health-Promoting Behaviors or Preventive Health Behaviors:

Patient Disclosures and Physician Lifestyle Advice

in the Primary Care Consultation

by

Clara Ann Blomgren Bergen

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2019

Professor Tanya Jean Stivers, Chair

People perform hundreds of health-relevant actions each day. These actions accumulate to form behavioral patterns which are the primary predictor of mortality in the United States. With studies establishing significant links between lifestyle and health outcomes, communities are in debate about where to draw the line between promoting population health and recognizing individual autonomy over lifestyle. These lines are negotiated daily in the routine clinical encounter. This line is drawn each time a medical professional makes a bid to supervise or direct a patient's lifestyle decisions. The line is erased and redrawn each time a patient resists a physician's lifestyle directive and accounts for that resistance. This dissertation examines a large and diverse sample of video-recorded routine primary care consultations, presenting a detailed analysis of patient reports of 'medically problematic' behavior and physician responses to these reports. Following a

disclosure of a medically problematic behavior (e.g., admitting to smoking or not exercising), a doctor may advise a patient to change their behavior. Chapter 2 asks whether and when individuals treat doctors as having the right to supervise and enforce a lifestyle change. Self-presentation and framing of behavior are an inevitable part of the social reality of disclosure. Chapter 3 asks whether patients in low-income communities of color and high-income white communities frame medically problematic behavior in systematically different ways. The reporting of routine medical test results (e.g., blood pressure) is systematically coupled with discussions of lifestyle. In Chapter 4, I examine the etiology and treatment discussions that follow reports of problematic lab results, and I explore how physicians and patients manage explicit and implicit attributions of fault in this context.

This dissertation of Clara Ann Blomgren Bergen is approved.

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CHAPTER 1

TALKING ABOUT HEALTH BEHAVIORS:

THEORETICAL AND METHDOLOGICAL CONSIDERATIONS

1.1 Introduction

People perform hundreds of health-relevant actions each day. We eat cookies, smoke cigarettes, lift heavy boxes at work. These actions accumulate to form behavioral patterns which are the primary predictor of mortality in the United States, more significant than genetic factors, healthcare quality, and environmental factors (McGinnis & Foege 1993; McGinnis, Williams-Russo & Knickman 2002). Cigarette smoking is still responsible for one in five deaths annually (US DHHS, 2014), and drinking is responsible for one in ten among working-age adults (Stahre et al, 2014). Diet has been identified as a risk factor contributing to 26% of deaths (US Burden of Disease Collaborators, 2013).

While billions of dollars are dedicated to developing new research on health management, substance use therapies and daily medications, little attention is paid to the actual situations in which these resources are transferred – the healthcare consultation. Ultimately, health outcomes are determined and health disparities emerge when patients discuss home health behaviors, seek resources, and learn new information. They also emerge when doctors adjust healthcare agendas and allocate resources.

This dissertation presents a detailed analysis of patient reports of ‘medically problematic’ behavior in the clinical encounter and physician responses to these reports. Bergen & Stivers (2013) show that patients orient to these reports as *disclosures of medical misdeeds* – defining the act of disclosure as “seeking care by revealing personally significant information that exposes the bearer to the risk of rejection or negative judgement.” (Saiki & Lobo, 2011). Likewise, this

dissertation examines reports in which patients themselves are communicating an orientation towards the behavior as a disclosure, or as medically problematic. The dissertation uncovers patterns in patient responses to physicians' behavior change advice and addresses the question of how health disparities are realized through variation in physician and patient approaches to discussing health behaviors.

1.2 Health Behaviors: Patient Agency and Physician Authority

1.2.1 Defining 'Healthy Lifestyle'

Interest in wellness activities, particularly around diet and exercise, has expanded greatly since the 1970's, impacted by both scientific findings and cultural changes (Conrad 1994). Conrad conceptualizes this trend as a "wellness revolution" in which individuals who identify with the moral discourse consider engagement in wellness activities as a moral good in itself, regardless of health outcomes. The pursuit of wellness is one of just a few undisputed paths of individual moral action in our society (Gillick 1984). Wellness seekers create a morality of the body, in which actions are categorized on a moral continuum and wellness is seen as a virtue (Conrad 1994). Health promotion, based on individual responsibility for health and lifestyle change, has evolved into a "new health morality" (Becker 1986).

There is also more public awareness than ever before about the health impacts of diet, exercise, smoking, and other behaviors (Kleindorfer et al 2009; Mosca et al 2010; see Moynihan, Heath & Henry 2002) in part due to the dissemination of health information online and through social media (Silk et al 2008). Public interest in adopting a health-conscious lifestyle is rising steeply among younger generations (Oliver Wyman 2017; Conrad 1994). Americans spend over 4.2 trillion USD annually on wellness commodities such as weight loss and preventive care

products, and the global wellness market is growing at almost twice the rate of the global economy (Global Wellness Institute 2017).

Despite this, health behavior trends are mixed. Since the 1980's the percentage of US adults who exercise at least three times a week has decreased by 19% and the percentage who eat 5 servings of fruit and vegetables daily has decreased by 38% (King et al 2009). Moderate alcohol use is up by 28% since the 1980's (King et al 2009) and high-risk drinking has increased by 30% just since 2001 (Grant, Chou & Saha 2017).

Modern Americans are faced with an excess of information about how to lead a healthy lifestyle, and the large majority report receiving conflicting information from multiple sources, causing confusion and heightened stress (IFIC 2017). Individuals end up relying on health information from sources they largely don't trust. While friends and family are the most frequently cited source of nutrition information, they are also considered untrustworthy sources, approximately equivalent to blogs and news articles (IFIC 2017). Over half of adults doubt the nutritional choices they make, and this percentage is even higher for millennials (IFIC 2017).

Patient and physician beliefs about health behaviors are often misaligned. For example, one widely held belief worldwide is that stress is the primary cause of hypertension. This belief is not backed up by the medical literature, but it nonetheless leads adults to stop pharmaceutical treatment without consulting their doctor during periods of low stress (Marshall, Wolfe & McKevitt 2012). Patients' beliefs about health behaviors are also shaped by advertisements and product marketing – for example, adults will recurrently rate certain recognized branded foods as healthier than others, even when shown two products with identical nutritional information (IFIC 2017).

One recent survey found that healthcare professionals are the only source of nutritional information that adults both rely on and trust, while health-focused websites, government agencies and scientific studies either weren't trusted or weren't used (Food Insight 2019). But what is a healthcare professional's role in this changing environment? Contemporary primary care providers perceive patients to be resistant to discussions of lifestyle, as well as to lack insight and motivation to change health behaviors (Jansink et al 2010; Lambe & Collins 2010). Physicians report low levels of systematic treatment and referrals following disclosure of smoking and lack of exercise (Orleans et al 1985). Primary care physicians are not spending any more time today discussing nutrition or alcohol than they were in the 1970's (Noordman, Verhaak & van Dulmen 2010). Lifestyle discussions occur in only 53% of primary care consultations in the United States and only half of these discussions involve lifestyle *counseling* (Russel & Roter 1993). Lifestyle counseling also disproportionately directed towards older men (Russell & Roter 1993; Noordman, Verhaak & van Dulmen 2010).

While the literature on the “wellness revolution” and health information-seeking (Conrad 1994; Food Insight 2017) might indicate that patients and physicians would be spending more time discussing health behaviors and would feel comfortable discussing health behaviors, this is not the case (Jansink et al 2010; Lambe & Collins 2010; Noordman, Verhaak & van Dulmen 2010). This suggests that there are additional layers to the social reality of *talking about lifestyle* in the clinical setting. In this dissertation, I argue that one of these layers is situated in modern patients' orientations to the role of the physician and the legitimacy of physician surveillance over home health behaviors.

1.2.2 Health Behaviors and Surveillance Medicine

As the sources individuals rely on for health information change and the prevalence of medically problematic health behaviors increase, public health organizations and government agencies are promoting physician supervision over patients' lifestyle as part of broad preventive healthcare agendas (e.g., Kanter 2013). Following the passage of the Affordable Care Act, most health insurance plans in the United States are required to provide free counseling on diet and exercise if an individual is clinically obese (US Preventive Services Task Force 2019). Tobacco cessation coverage, for example individual counseling by a physician and cessation prescriptions, must also be provided at no cost (McAfee et al 2015). Integrated managed care consortiums such as Kaiser Permanente are also shifting towards increased supervision over health behaviors to lower costs associated with chronic illness management (e.g., Kanter 2013).

Physicians themselves even claim increasing rights to supervise a patient's health relevant behaviors. Sociologists describe this process as the rise of *surveillance medicine* (Armstrong 1995) and have explored the expansion of surveillance medicine to areas including alcohol use (Schneider 1978), fitness (Wheatley 2005), and lifestyle broadly conceived (Crawford 1980). Where surveillance medicine is prevalent a sense of responsibility for one's health is internalized and thereby functions to turn "health into the moral" (Conrad 1992, 1987).

The expansion of surveillance medicine is also intertwined with the expansion of medicalization more generally (Hislop & Arber 2003). Medicalization is the process by which physical and mental conditions come to be defined as medical conditions and treated with medical interventions (Conrad 2007; Clarke et al 2003). The medicalization of pregnancy (e.g., Fox & Worts 1999) and obesity (e.g., Salant & Santry 2006) are two particularly well-researched examples. Similarly, Hislop and Arber (2003) show how the rise of medical surveillance mobilizes medicalization, using the case of sleep. As physicians increase their supervision of sleeping habits,

they create situations in which diagnosis and treatment become socially relevant. At the same time, as sleep becomes medicalized and ‘sleep disorders’ are examined in medical research, the medical supervision of sleeping habits is legitimized.

The epidemiological transition from the prevalence of disease to the prevalence of chronic illness has also fueled the rise of surveillance medicine. While social scientists maintain that this transition has been driven by social and cultural change (Starr 1982; Turner 1987), the biomedical perspective maintains that this shift is a result of increasing life expectancy and the expansion of evidence based medical research (Martin & Peterson 2009). Nonetheless, social scientists and medical researchers agree that as people come to *live with illness* rather than *die from disease*, their everyday lives are increasingly folded into the medical domain.

Contemporary medical practitioners are expected to implement four levels of preventive care (Martin & Peterson 2009) under the “expanded chronic care model” (Barr et al 2003). Each level contributes to a unique facet of patients’ experience of surveillance medicine in the clinical encounter. Primary prevention can be defined as action taken to *remove* the potential cause of a health problem before it arises. This has contributed to physicians’ supervision of behaviors categorized as risk factors for chronic conditions which themselves are categorized as risk factors for disease. An example of this would be physician supervision of diet on the basis of rising blood pressure, which could turn into hypertension and thereby increase the patient’s risk of heart disease (Viner et al 2006). In part, Chapter 4 of this dissertation explores patient responses to the enactment of primary prevention in the healthcare consultation.

Secondary prevention involves actions taken to *detect* a health problem at an early stage to prevent it from worsening (Martin & Peterson 2009). One consequence of this is the expansion of the ‘sick role’ (Parsons 1951) and accompanying medical interventions, for example physician

surveillance of blood sugar levels for patients diagnosed with pre-diabetes. Tertiary prevention includes actions taken to *reduce* the effects of a diagnosed chronic health problem before it manifests as disease. For example, this could involve specialized nutritional counseling for patients diagnosed with diabetes. Chapter 2 of this dissertation explores patient responses to physicians' lifestyle advice when it is, versus is not, framed as addressing a diagnosed chronic health problem. Finally, quaternary prevention can be defined as actions taken to *counteract* potential adverse consequences of other forms of preventive medical intervention, an example of this being physician surveillance of kidney function in instances of potential overmedication (Veehof et al 2000).

These findings illustrate the extent to which the role of the physician has changed under the expanded chronic care model (Barr et al 2003; Starr 1982) as patients come to *live with illness* rather than *die from disease*. As new and varied forms of medical surveillance become mainstream, the changing role of the physician affects the modern physician-patient relationship. However, these social processes move in the other direction as well. The increasing domains of preventive care, medicalization, and medical surveillance also change the patients' role, and the extent to which patients are expected to integrate medical advice into their everyday lives.

1.2.3 Nonadherence

As the scope of medical surveillance increases in the United States, so does the sphere of patient behaviors that can be labeled *nonadherent*, or going against medical advice. There have been unprecedented advances in evidence-based medical research on the association of everyday behaviors with the risk of health incidents such as stroke and heart attack. Today, physicians can link a patient's risk of heart attack not only to diet and exercise, but to their use of over-the-counter calcium tablets (Bolland et al 2010) and their flossing habits (Reichert et al 2014). This greatly

expands the range of behaviors that physicians will advise patients on and hold patients accountable for, which in turn affects the modern physician-patient relationship.

Similarly, as pharmaceutical treatment for chronic illness expands, patients are expected to adhere to medication regimens for years at a time, sometimes indefinitely. Patient adherence to long-term medication regimens is not particularly high. On average, the rate of medication adherence among individuals with diabetes is 68%, cardiovascular disease is 76%, and pulmonary disease is 69% (DiMatteo 2004). Because of the significant medical benefits associated with adherence to pharmaceutical treatment for common chronic conditions, there is an abundance of research on the promotion of pharmaceutical treatment adherence (Martin & DiMatteo 2014). As the literature on treatment adherence from a contemporary biomedical perspective has grown, so has a sociological literature on treatment adherence from the patient perspective.

“Noncompliance” frameworks (Lutfey & Wishner 1999) have been criticized by sociologists and health communication scholars for advancing a paternalistic ideology in medicine. Sociologists have argued that “noncompliance” frameworks orient to patients as passive recipients of their home health regimens, which is inaccurate and attaches unwarranted stigma to “noncompliant” patients. With such an idealized orientation towards proper roles of patients, this framework treats noncompliance as irrational and deviant, and does not leave room for conflicting contextual factors or patient agency (Donovan & Blake, 1992; Haynes, 1979; Playle & Keeley, 1998).

Relatedly, “noncompliance” frameworks have been criticized by health communication scholars as referencing a more idealized paternalistic approach in healthcare. In this field there is a trend towards discussions of “adherence” frameworks to reference a more collaborative relationship between patient and doctor in health management (Martin & DiMatteo, 2014; Lutfey

& Wishner 1999). This distinction is also reflected in the World Health Organization's definition of adherence (WHO, 2009). Regardless of the label, in the context of the clinical encounter, when patients present themselves nonadherent, this involves attributions of fault and accountability. Physicians and patients in healthcare settings display clear recognition of this in their talk.

Much of the literature on patient nonadherence does not fully account for the multi-faceted nature of behavior change – nonadherence with medical advice is most often due to the fact that a given health regimen is incompatible with a person's life (Zola, 1981). Very often, patients consider their health behaviors as reasonable, given other contextual factors in their lives and their understanding of the illness (Becker & Maiman, 1975). This is reflected in the video-recordings analyzed for this study, as patients simultaneously display an orientation to their behavior as reasonable given other circumstantial factors and to their behavior as going against medical advice. These health-relevant behaviors are deeply embedded in people's home lives, practical challenges, conflicting responsibilities, and socioeconomic barriers. They are, therefore, also deeply embedded in identities of power, compliance and rationality (Conrad, 1985; Trostle, 1988; Playle & Keeley, 1998).

Sociologists studying medication adherence have shown that patients see their participation in the medication regimen as a rational cost-benefit analysis, as opposed to a simple adherence-nonadherence assessment (Donovan & Blake, 1992; Pound et al, 2005). These studies take a grounded approach, recommending that the medical literature move past studies of 'obedience' and study patients' home health behavior through the lens of the patient and their decision-making process. However, medical sociologists and health communications scholars must balance this insight with the recognition that certain health behaviors can be damaging, and medical professionals may not conceptualize nonadherence in the same way as patients or sociologists.

Beyond the literature on patient adherence, we see a similar type of friction in the literature on patient accountability for health outcomes.

1.2.4 Personal Responsibility and Stigma

Many medical professionals consider adults personally responsible for certain health outcomes, particularly those linking nonadherence to ‘healthy’ lifestyle practices (Fleming & Szmukler 1992; Maroney & Golub 1992; Phelan et al 2015). Over half of health practitioners surveyed in one community hospital believed obesity could be prevented if their patients exerted more self-control (Maroney & Golub 1992). Health practitioners surveyed in one general hospital considered patients with eating disorders and advanced substance abuse disorders to be largely responsible for their condition (Fleming & Szmukler 1992). These biases translate to clinical behavior. For example, OB-GYN practitioners cite poorer self-management among overweight and obese pregnant women, report more negative attitudes towards caring for these women, and also respond less positively to these women in the consultation (Mulherin et al 2013).

Patients not only recognize this bias in physicians’ behavior (Kinsler et al 2007; Chapple, Ziebland & McPherson 2004), but interpret this behavior as discriminatory (Bombak, McPhail & Ward 2016). Both non-smokers and smokers diagnosed with lung cancer report feeling unjustly blamed for their cancer by oncologists (Chapple, Ziebland & McPherson 2004). Individuals diagnosed with HIV/AIDS still perceive considerable stigma from their healthcare providers in the United States (Kinsler et al 2007). Pregnant women recognize many different forms of obesity stigma (Mulherin et al 2013) in prenatal care (Bombak, McPhail & Ward 2016). These interactions not only impact the quality of patients’ care, but their propensity to seek follow-up and preventive care in the future (Kinsler et al 2007).

Sociologists and public health scholars have, over the years, debated the mobilization of stigma on a more macro level to pursue public health ends such as smoking cessation (Bell et al 2010; Bayer 2008). Even prominent sociologists have suggested that to reduce the prevalence of certain behaviors, it is effective and therefore critical to mobilize stigma in the context of certain public health crises (Bayer, 2008). However, others have argued that mobilizing stigma in this way places an undue burden on underserved communities (Bell et al 2010). By moving to the micro-interactive level, we can observe how, in various contexts, physician communication of judgement impacts patient willingness to engage on a discussion of home health behaviors. Moving away from broad, interactionally-decontextualized debates, this research explores the grounded social reality of depictions of fault in medical institutions.

1.3 Bridging Micro and Macro

1.3.1 Social Mechanisms

Social theorists have argued that a sole reliance on statistical associations can produce black box explanations for social phenomena, in which the mechanisms through which social processes take place are not addressed (Hedstrom & Swedberg, 1998). This approach produces findings that can be easy to misattribute or discount because a discussion of the paths through which X is associated with Y is notably missing from the story. Hedstrom and Swedberg even pinpoint the study of the associations between class and health outcomes as a particularly problematic line of research in this respect (1998).

This is of particular relevance today, as social media and mainstream media are used to attribute mechanisms to social scientific research findings. For example, when a recent study came out suggesting that an expansion of Medicaid would result in an overall increase in emergency room visits (Taubman et al., 2014), it didn't fully explain the social mechanisms driving this

relationship. US media outlets attempted to fill in those gaps. There was widespread misattribution of the mediating social mechanism. News articles suggested that increased access to Medicaid caused low-income people to unnecessarily overuse services just because they were cheap, when there was no direct evidence of this (Associated Press, 2014; Rovner, 2014; Cook, 2014). Additionally, without an explanation for this association that governments could act on, the Taubman et al. (2014) article has been cited as a justification for states not to expand their Medicaid programs (Royse et al., 2015, pg. 7).

Since Taubman et al.'s influential 2014 publication, significant work has been done to try to explain *why* those with first-time access to Medicaid might utilize the ER at an increased rate. For example, after conducting an extensive literature review, as well as interviews with healthcare providers and healthcare researchers, the United States Department of Health and Human Services found that a lack of access to primary care offices that offer same-day appointments, after-hours care, and 24/7 nurse advice lines, mediate the relationship between first-time access to Medicaid services and increased use of Emergency Rooms (Mann, 2014). In this light, Taubman et al.'s findings can be used, for example, to help justify an increase in funding for 24/7 nurse advice lines for Medicaid patients, as opposed to justifying states' decisions not to expand Medicaid.

Stories such as these support the pursuit of a mechanisms-based approach to the study of population health behaviors – particularly when researching health behaviors of people of color and individuals with lower income or education. However, when mechanisms are addressed in the literature on treatment and health disparities, they are overwhelmingly addressed at the mezzo and macro levels. In an expansive review of race-based treatment disparity literature published by the Institute of Medicine (IOM), it was stated outright that the research team was only able to locate

limited research on the micro-social and interactional mechanisms through which these treatment disparities emerged (Smedley et al., 2003).

This approach to mechanisms research assumes that mechanisms do not necessarily have isolated, independent effects on the outcome, but instead are often dependent on one another and interact with one another in complex ways before influencing the outcome. For this reason, the methodology I rely on in this dissertation – conversation analysis (CA) – is a particularly well-suited methodology for this approach to studying social mechanisms. The identification of the social actions performed through interactional practices is grounded, in large part, in the contexts in which these practices occur (see Sidnell & Stivers, 2012). It is acknowledged that one actor's behaviors can be understood only in the context of the ongoing social interaction, so that the analysis of one practice is never fully separated from broader social and interactional contexts.

1.3.2 Healthcare Disparities

The limited research that has been published in this field indicates that the healthcare consultation is a key site for the realization of health disparities. Among other factors, physicians report making treatment recommendations based on assessments of patient cognitive ability, motivation, and social support (Lutfey et al, 2008). Such assessments are significantly associated with demographic factors such as race (Lutfey & Ketcham, 2005). Providers' assessments of patient intelligence and abilities are also significantly associated with patient race and socioeconomic status, respectively (van Ryn & Burke, 2000). For example, physicians perceive African American patients to be less likely to adhere to medical advice and low-SES patients to be less likely to want to live an active lifestyle or participate in rehabilitation (van Ryn & Burke, 2000).

Low-SES patients receive a less participatory consulting style in the healthcare visit generally (Willems et al, 2005). Patients with less than a high school education and non-white patients report the lowest levels of involvement in healthcare decisions, which will primarily be carried out in the home (Kaplan et al, 1995). Patients with high education receive more diagnostic and health information than others (Street, 1991), while those with low education tend to receive a more directive style of doctoring, with less time spent on patient questions, negotiating, and counseling (Fiscella et al, 2002).

Sociologists have used Cultural Health Capital (Shim 2010) to conceptualize how certain interactional approaches, for example displaying a knowledge of medical vocabulary and displaying a value of self-discipline, can be rewarded by healthcare professionals in the clinical setting. Similar to Bourdieu's (1980, 1983) Cultural Capital, certain patients are taught to *mobilize displays* of Cultural Health Capital. The use of these communicative resources becomes largely habitual and unconscious, both arising from and contributing to social stratification (Shim 2010). This final point is particularly relevant when we consider how many low-income adults have been shut out of accessing basic healthcare services due to the cost of insurance, and therefore have spent less time in medical settings interacting with healthcare professionals.

For years, the United States has topped rankings for least accessible healthcare services among high-income countries. This can largely be traced back to the sheer unaffordability of basic clinical services and pharmaceutical treatments for low- and mid-income patients (Schoen et al., 2010; Davis et al., 2014). As of 2013, it was estimated that almost 40% of those with below-average income would avoid seeing the doctor about a medical issue at least once annually due to cost alone, twice the rate of those with above-average income (Davis et al., 2014).

This lack of access to care, and resulting health outcomes, is most clearly seen in the context of routine and preventative services for common chronic conditions such as diabetes and asthma. As of 2013, it was estimated that one third of patients with common chronic conditions did not receive a recommended test, treatment, or clinical follow-up for their chronic illness at least once annually due to cost (Davis et al., 2014). Among high-income countries, the United States has some of the highest rates of hospitalization due to uncontrolled chronic illness, including congestive heart failure (4 times the rate in the UK), asthma (7 times the rate in Canada), and diabetes (57 times the rate in New Zealand) (Squires, 2011).

It has also been well established that access to adequate healthcare services is highly stratified not only by income, but also independently by race (Smedley et al., 2003). Again, this stratification in access to care is most clearly seen in the context of routine and preventative services for common chronic illness. For example, black Americans with diabetes are significantly less likely to undergo recommended hemoglobin testing, lipid testing, eye examinations, and influenza vaccinations relative to white diabetics, even when limiting the study population to Medicaid recipients and controlling for relevant demographic factors (Chin, Zhang & Merrell, 1998).

In 2014, a number of key provisions of the Affordable Care Act (ACA) took effect. For the first time, insurance companies could not deny people insurance or charge higher rates for insurance because of diagnosed chronic illness. Medicaid has also been expanded (optionally, by state) so that in many states all persons below 133% of the federal poverty line are eligible to enroll, and tax credits will be given to persons up to 400% of the poverty line to help them afford private insurance.

It has become only increasingly clear that, as a country, we cannot erase decades of stratified accessibility of adequate clinical care through these provisions alone (Taubman et al., 2014; Baicker et al., 2013). With respect to Americans' social understandings of the healthcare system, we are still largely faced with a system of buy-in entitlement to access fee-for-service care. Studies have established that, for example, having been previously denied care by a doctor's office is significantly predictive of choosing to use the emergency department as a regular source of care, even when controlling for current insurance status (O'Brien, 1997). Essentially, we find that patients who have spent the majority of their adult lives facing barriers in access to basic health services interact with the healthcare system in a fundamentally different way than those who have not faced these access barriers.

Ethnographic work on this subject has shown to what extent the effects of these barriers, as they interact with the direct effects of poverty and structural racism, permeate through all aspects of life in the United States – including underserved groups' social understandings of physicians and healthcare systems. Common themes include a sense of futility in attempting to secure quality care (e.g., Abraham, 1994) and a sense of disjuncture with physicians that do not seem to fully comprehend the costs of securing recommended tests, treatment, and follow-up care and maintaining recommended lifestyle adjustments (e.g., Lutfey & Freese, 2005).

It is not only well established that health behaviors such as treatment adherence, diet, and exercise have a significant impact on morbidity and mortality (Schroeder, 2007), but moreover that underserved and low-income patients are at greatest risk of such negative impacts on health (Brown & Bussell, 2011; Adler et al, 1994). These same patients are also most likely to face a broad range of more serious health concerns (Braveman & Gottlieb, 2014; Link & Phelan, 1995)

and are most likely to feel that their concerns are being ignored by their doctor (O'Malley et al, 2004; Doyle, Lennox & Bell, 2013).

In the wake of major political upheaval surrounding the Affordable Care Act, now is a critical time to re-examine the extent to which disparities in quality of and access to care permeate the social reality of American healthcare. For the first time, we will expect to see higher rates of access to basic primary care services. However, there is also no evidence suggesting that access to other important clinical resources, such as time in the primary care consultation, will not continue to be stratified by income, employment status, and race. Healthcare providers' implicit biases are still strong (Phelan et al 2014). Importantly, patients' histories of non-access will not be erased, and social practices will be informed by these personal histories (Shim 2010).

1.4 The Clinical Encounter

1.4.1 Conversation Analysis and Physician-Patient Communication

Conversation analysis addresses the interplay of social interaction and action, drawing evidence from observable features of naturally occurring conversations between doctor and patient. The field has made methodological advances in the analysis of talk and social interaction that produce a high standard of reliability and validity (Heritage & Maynard 2006a). Over the past 30 years, conversation analysis has been growing in popularity as a way to approach a systematic analysis of physician-patient interactions (see Peräkylä 1997; Maynard & Heritage 2005; Gill & Roberts 2013).

The process of action formation and ascription is central to the field of conversation analysis. The achievement of social interaction is dependent on each person's turn at talk being hearable as a social action, such as a greeting or an invitation. A speaker must assign at least one major action to the other's turn at talk in order to establish what is relevant next and build their

own turn at talk (see Levinson 2012). Speakers rely on a variety of interactional clues in the action recognition process, including sequence organization, turn design, and interactional context, each of which I touch on below. Turns at talk can also perform more than one action. For example, “*Do you have an automated medication dispenser at home?*” can be both a request for information and a pre-recommendation for purchasing a medication dispenser. Actions also contribute to overarching activities and projects. Returning to the prior example, the pre-recommendation could be hearable as contributing to the project of promoting medication adherence if it were to follow a disclosure of forgetting to take medications.

In the clinical encounter, patients’ and physicians’ turn designs are sensitive to the medical and interactional exigencies in play (Heritage & Maynard 2006a). Turn design is shaped by sequence and action, and can perform a variety of functions. For example, turn design can index an agenda (e.g., Stivers 2002) or display authority (e.g., Toerien, Shaw & Reuber 2013).

The microanalysis of the organization of sequences in interaction distinguishes conversation analysis from other approaches to the study of social interaction (see Stivers 2012; Schegloff 2007). Sequence organization is integral to the achievement of interactional roles, institutional identities, and formation of actions and projects. For example, we can recognize that a routine history-taking sequence is primarily organized as a series of question-answer adjacency pairs that will in some instances involve non-minimal post-expansion (Boyd & Heritage 2006).

The study of context, including the institutional setting, interactional role, project and agenda, have progressively become more prominent in the field of conversation analysis (see Heritage & Clayman 2011). One well known example is the study of the phase structure of the acute primary-care consultation. These consultations typically follow a specific progression of activity phases – opening, problem presentation, history taking and physical examination,

diagnosis, treatment recommendation, and closing (Byrne & Long 1976; Robinson 2003; Heritage & Maynard 2006a).

The study of the clinical encounter has been a central research topic in the field of conversation analysis for decades (for reviews, see Peräkylä 1997; Maynard & Heritage 2005; Heritage & Maynard 2006b; Pilnick, Hindmarsh & Gill 2009; Gill & Roberts 2013). Conversation analysts have explored a wide array of clinical activities, from the opening of the consultation (Robinson 1998) to its very end (Robinson 2001). In the following pages I outline some of the most relevant conversation analytic research on clinical interaction as it pertains to the study of physician-patient discussions about health behaviors.

There has been limited conversation analytic work directly addressing physician-patient conversations about lifestyle (but see Pilnick & Coleman 2003; Halkowski 2012). Pilnick and Coleman (2003) examine UK general practitioners' problematizations of smoking, including negative assessments, assertions of risk, behavior-change advice, and pursuit of patient acknowledgement of the behavior as problematic. They find that moderate smokers routinely resist the problematization of their smoking behavior, whether or not physicians identify smoking as contributing to the patient's health concern. Halkowski (2012) examines how patients formulate descriptions of their alcohol use in the talk following a physician's routine history-taking question about alcohol. He demonstrates a range of interactional practices patients use to present their drinking behavior as not troubling or not medically relevant, including resisting temporal metrics such as 'every weekend' and instead relying on negative observations (e.g., 'not every day') and characterizations (e.g., 'occasionally'). In this way, patients formulate their drinking behavior as *not a regularized pattern* of drinking. Notably, these studies examine discussions of a behavior that the patient *does not* orient to as medically problematic, but the physician *may* orient to as

medically problematic. In contrast, this dissertation examines discussions about a health behavior that the patient does orient to as medically problematic, as will be discussed in the Data and Methods section of this chapter.

Beyond the studies presented here, conversation analytic research on discussions of health behaviors is developing (Albury et al 2018) but still largely unpublished (Albury 2017; Connabeer 2017). Nonetheless, existing conversation analytic research provides a strong foundation for the study of lifestyle discussions in the medical setting. I begin with the subjects of treatment and advice, as they relate to the current study of lifestyle advice.

1.4.2 Treatment Recommendations and Advice-Giving

The communication of a treatment recommendation is a central topic of interest conversation analytic research on routine healthcare consultations (Stivers 2002, 2005; Hudak, Clark & Raymond 2011; Toerien, Shaw & Reuber 2013; Lindström & Weatherall 2015; Angell & Bolden 2015; Landmark, Svennevig & Gulbrandsen 2016; Fatigante et al 2016; Thompson & McCabe 2018; Stivers et al 2018; Stivers & Barnes 2018). Primary care consultations in which multiple health concerns are discussed do not necessarily follow the typical acute care format (Robinson 1999), though there is still an orientation towards the relevance of treatment for most health concerns. Talk about medically problematic health behaviors is often tied to treatment. For example, the most common activity patients pursue by initiating disclosure of a medical misdeed is treatment negotiation (Bergen & Stivers 2013).

In the conversation analytic literature, researchers typically focus on treatment recommendations for prescription or over-the-counter pharmaceutical treatment (Bergen et al 2018; Stivers & Barnes 2018; Landmark, Svennevig & Gulbrandsen 2016; Stivers 2002, 2005; Robinson 2001) or recommendations for specific medical interventions such as surgery (Hudak,

Clark & Raymond 2011) or chemotherapy (Tate 2018). Physicians can also build other recommendations, such as recommendations for lifestyle changes, as treatment recommendations, if they indicate that making the behavior change would functionally ‘treat’ a known health condition. Advice giving in the healthcare setting (Heritage & Sefi 1992) and treatment recommendation are distinct activities, though not mutually exclusive. While a treatment recommendation indicates that the recommended intervention is meant to directly address a specific medical condition, advice simply communicates physician endorsement of an intervention. For example, Heritage and Sefi (1992) explore health visitors’ advice to new mothers – this advice is not framed as treatment for a *medical condition*, but rather medically sanctioned instruction on how to care for a new baby.

We know that physicians consider lifestyle advice an important component of primary care (Arborelius et al 1992). However, almost three in four primary care consultations involve no lifestyle counseling whatsoever (Russel & Roter 1993). In part, this may be due to the interactional challenges involved in advice-giving, as patient resistance towards advice can take time away from other important topics and even damage the physician-patient relationship. It’s been shown that resistance towards health advice is prevalent, particularly among sensitive populations such as first-time mothers and patients receiving treatment for HIV/AIDS (Heritage & Sefi 1992; Kinnell & Maynard 1996). In Cognitive Behavioral Therapy sessions for individuals with depression, clients typically respond to behavior-change advice with active resistance (Ekberg & LeCouteur 2015). Asynchronous or sequentially premature advice is especially likely to be resisted, in part due to the sensitive nature of shifting roles from troubles-teller to advice-recipient (Jefferson & Lee 1981). Even where patient resistance to advice is not present, a lack of patient uptake can also halt progressivity. Patient uptake is required for an advice-giving sequence to persist over several

turns at talk, and this uptake is not always achieved (Pilnick 1999). As such, any study of physician advice-giving will necessarily involve a detailed analysis of patient response to layers of action, activity and topic.

1.4.3 Diagnosis and Etiology

Like recommending treatment, diagnosis is also a complex, layered activity. Diagnosis is often treatment-implicative (Stivers 2007), it can involve the communication of uncertainty (Heritage & McArthur 2019), and it may align with or go against patients' diagnostic theories (Stivers 2002). Physicians are also accountable for providing an evidential basis of diagnoses in primary care (Peräkylä 1998). This can be seen in physicians' use of online commentary, the design and placement of diagnostic utterances, and the explicit problematization of lack of evidence (Peräkylä 1998; Heritage & Stivers 1999; McArthur 2018). Evidence can also play a more complex role in the diagnostic process, an example being psychiatrists' interactional work to help patients recognize their own narratives as evidence of addiction (Halonen 2006).

While *diagnosis* is a clearly defined activity with an established position in the clinical phase structure (Robinson 2003), the interactional regularities of the *report of the routine test result* are largely unknown. In a recently published dissertation on clinical interaction in routine Type II diabetes check-ups, Gelcich (2017) argues that the reporting of blood-glucose results should not be considered part of the *diagnostic phase*, but rather as a part of the *examination phase* along with the weight check and foot check. She finds that nurses and patients orient to the reporting of blood-glucose results as a *monitoring examination*.

The activity of establishing the etiology, or cause, of a health issue has also been examined in the conversation analytic literature, though to a lesser extent. Patients' attributions of cause of illness have been the central focus of research in this area. For example, Gill (1998) examined how

patients manage epistemic imbalances when proposing potential causes of illness. Bergen and Stivers (2013) showed that patients may use a disclosure of a medical misdeed to promote a specific etiology. Gill and Maynard (2006) have also examined physician responses to patients' candidate etiologies.

As we start to see in this brief review, any conversation analytic study of diagnosis or treatment is necessarily embedded within broader frameworks of authority deriving from institutional roles (e.g., doctor) and social identities (e.g., older adult). Stepping back, I provide a brief review of the conversation analytic literature on deontic and epistemic authority – two analytic tools that can be used to organize a study of the diagnosis- and treatment-relevant actions we will see recurrently throughout the dissertation (e.g., directing and informing).

1.4.4 Deontic and Epistemic Authority

Deontic authority can be conceptualized as one person's rights to direct or determine another person's activities (Stevanovic & Peräkylä 2012; Stevanovic 2013). Epistemic authority can be conceptualized as a person's rights to assert primary knowledge relative to another person on the basis of experience (Pomerantz 1984) or social identity (Heritage & Raymond 2005). When patients and physicians assert and resist these forms of authority, they reveal the moral orders they are working within. The field of Conversation Analysis examines a micro-interactional moral order “cut from the same cloth as other forms of moral reasoning” (Stivers, Mondada & Steensig 2011). Moral calibrations are continually made at the level of social interaction. Often these calibrations relate to epistemic or deontic rights and institutional authority.

Conversation analysts have studied the role of deontic authority in the healthcare setting extensively (see Lindström & Weatherall 2015; Dalby Landmark, Gulbrandsen & Svennevig 2015). Importantly, social actions can be conceptualized as holding various strengths along a

deontic gradient (Stevanovic 2013). For example, a physician may direct a patient to exercise daily (asserting higher deontic authority) or offer a range of exercise and diet options through *option listing* (asserting lower deontic authority) (Stevanovic & Peräkylä 2012; Toerien, Shaw & Reuber 2013). Responses to first actions also implicitly accept, resist or negotiate the deontic authority claimed in the first action. For example, a patient could resist the physician's claim of deontic authority over their exercise regimen by asserting they won't have time to exercise daily (Stevanovic 2013). The deontic gradient is not only interactionally produced and negotiated, but it can also change many times during a conversation, as talk shifts to activities or topics over which one individual can claim higher deontic authority (Rossi 2012).

The organization of epistemic authority in the healthcare setting has also been studied extensively by conversation analysts (see Maynard & Frankel 2006; Lindström & Karlsson 2016; Dalby Landmark, Gulbrandsen & Svennevig 2015). While patients typically assert primary knowledge over the illness experience and physicians assert primary knowledge over best-practice diagnosis and treatment procedures (Heritage & Robinson 2006, Peräkylä 1998, 2002), patients also display a willingness to mobilize medical knowledge gained online to resist treatment proposals (Lindström & Wetherall 2015), and all participants display a preference for an evidential basis for certain types of diagnostic claims (Peräkylä 1998).

Individuals not only have rights to assert primary knowledge, but also a responsibility to hold certain knowledge (Pomerantz 1980). A patient, for example, has a responsibility to know how often they drink alcohol and a physician has a responsibility to know about treatment options for alcohol use disorders. This extends to a responsibility to avoid certain types of actions within certain epistemic contexts (Stivers, Mondada & Steensig 2011). An example of this is the social

preference to *not* inform another of something they already know (Goodwin 1979; Sacks 1992: 441), as in a physician *informing* a patient that binge drinking is not medically recommended.

Research on the moral calibrations built around epistemic and deontic authority is inherently tied to patient self-presentation because patients negotiate relative positions of deontic and epistemic authority *through* self-presentation. A patient can, for example, work to present themselves as someone who is highly knowledgeable about the workings of their body, and therefore a credible source when reporting symptoms. I begin with this example.

1.4.5 Self-Presentation

Patients work to present themselves as credible when reporting symptoms; they regularly announce that others urged them to seek care, report that self-treatment has failed, and indicate that they were not looking for symptoms when they arose (Heritage & Robinson 2006; Halkowski 2006). This self-presentation work frames their health concerns as clinically relevant, as opposed to part of larger issues of paranoia or addiction. Self-presentation isn't limited to any one phase of the consultation or any one patient project. For example, patients also work to present themselves as reasonable when resisting a physician's diagnosis (Peräkylä 2002, 2006; Ijäs-Lakkio, Ruusuvaori & Peräkylä 2010; Gill 1998; Gill, Halkowski & Roberts 2001; Stivers 2002) and when negotiating treatment (Stivers 2002; Bergen & Stivers 2013).

An analysis of patients' self-presentation work is entwined with physicians' displayed orientations towards patients' credibility. For example, a patient's self-presentation work can both shape and be shaped by a physician's sanction of potential drug-seeking activities (Stivers 2002). Medical questioning is a subtle, but more prevalent, context in which physicians can display an orientation towards a patient's credibility. There is a social-interactional preference for questions designed to anticipate a medically preferred answer (e.g., *are you exercising*) unless there is

evidence that the medically preferred answer isn't true (Boyd & Heritage 2006). For example, a physician may ask "*Do you exercise at all?*" which anticipates a medically dispreferred no-type answer (Sacks 1987; Boyd & Heritage 2006). If a physician asks this question and the patient has not previously indicated not exercising, the physician is then hearable as orienting to other evidence that the medically preferred answer isn't true (e.g., weight bias or the patient's self-presentation, though we often have no access to what aspect of the patient or presentation the physician is orienting to).

Though conversation analytic literature has looked extensively at patients' self-presentation work, there has been limited research on variation in self-presentation work across demographic groups. However, ethnographic and survey-based research has shown that self-presentation plays a more central role in the healthcare consultation for certain populations. Malat et al (2006) find that African Americans and those with low education and income rate positive-self presentation as relatively more important for receiving quality care, when compared to whites and those with more education and income. This indicates that there are certain patient populations who believe the quality of their medical care is more or less conditional on their behavior during the consultation. Where Shim's theory of Cultural Health Capital (2010) emphasizes the habitual learned behaviors of individuals, Malat et al's work highlights patients' awareness of physician bias and the additional social-interactional work underserved patients do to secure quality care. A conversation analytic study of patient self-presentation in the context of the disclosure of a medically problematic behavior across healthcare centers in high- and low-income communities can uncover the ways in which these layers of reality cooperate and collide.

1.5 Data and Methods

1.5.1 Data Collection

Conversation Analysis contributes to a body of scholarship on video-recorded doctor-patient interaction and the interactional achievement of the healthcare consultation; for example, the establishment of the validity of the patient's concerns (Heritage & Robinson, 2006), of the (in)adequacy of pharmaceutical treatments (Stivers, 2005; Bergen et al, 2017), and of the patient's body as an object of clinical inquiry (Heath, 2006). All data collected for this dissertation followed conventional procedures for Conversation Analytic work, including collecting video and audio recordings for the healthcare consultations in full. A camera was set up in the examination room and no researcher was present during the consultation. All data were obtained under the proper IRB Permissions, and informed consent was obtained from all participants.

Whenever possible, patients were asked to complete a pre-visit survey collecting information on current medications, chronic-care diagnoses, regularity of health consultations, relationship with physician, health insurance, prescriptions coverage, history of insurance, income, size of household, job status, job title, hours worked, education, parents' education, age, gender, and race. Select patients also participated in post-visit phone interviews, in which they were asked about health outcomes, health-relevant behavior change, and perceptions of the visit, among other things. Patient survey and interview data were not used for the dissertation but will be used for future publications.

1.5.2 Sample

Internal medicine and family practice physicians and their adult patients were eligible to participate in this study. The dataset consists of 180 video recordings of primary care consultations, collected across a diverse set of healthcare centers between 2014 and 2016. The data include recordings of 12 internal medicine or family practice physicians across seven practices in four cities within one major urban county in the United States. Nine female and three male physicians

ranged in age from 28 to 66, and they identified as Asian (7), Black (2), Hispanic (1), and non-Hispanic white (2). Adult patients were eligible to participate in the study if they were attending a pre-scheduled appointment with a participating primary care physician. While the large majority of patients discussed at least one chronic health concern during their consultation, patients with acute concerns only were also included.

In Table 1, I outline demographic characteristics of the immediate local area surrounding each of the primary care health centers. As the table makes clear, the sample can be roughly broken down into healthcare centers that provide care in low-income communities of color (Lowell and Lowry) and healthcare centers that provide care in high-income white communities (Highland and Hinsdale). The majority of adults in Lowry identify as African American and the majority of adults in Lowell identify as Hispanic.

	Consultations Filmed	Median Household Income	% Below Fed. Poverty Line	% Non-Hispanic White
Lowell	60	\$18,000	45%	7%
Lowry	16	\$28,000	35%	2%
Highland	39	\$118,000	1%	58%
Hinsdale	56	\$156,000	1%	83%

Table 1. Median income, poverty rate and racial distribution of immediate local area surrounding the healthcare center <http://www.city-data.com/>

Table 2, below, provides physician-identified visit and patient characteristics based on physician exit survey data. These visit and patient characteristics are also broadly reflected in video recordings and patient survey data.

	Visit Time Allotted	Doctor Feels Behind Schedule	Patient Income Bracket
<i>Lowell 1a</i>	15 Min.	Sometimes	Low to Middle
<i>Lowell 1b</i>	15 Min.	Almost Never	Low to Middle
<i>Lowell 2</i>	20 Min.	Almost Always	Low to Middle
<i>Lowell 3</i>	40 Min.	Almost Always	Heterogeneous
<i>Lowry 1</i>	20 Min.	Sometimes	Low to Middle
<i>Highland 1a</i>	20 Min.	Sometimes	Middle to High

<i>Highland 1b</i>	20 Min.	Sometimes	Middle to High
<i>Highland 1c</i>	20 Min.	Very Often	Middle to High
<i>Hinsdale 1a</i>	20 Min.	Very Often	Middle to High
<i>Hinsdale 1b</i>	15 Min.	Very Often	Middle to High
<i>Hinsdale 1c</i>	15 Min.	Very Often	Heterogeneous
<i>Hinsdale 2</i>	30 Min.	Sometimes	Heterogeneous

Table 2. Physician survey responses regarding visit time and patient demographics.

1.5.3 Collection Building

Conversation Analysis, my primary methodology, is used to expose communication practices: the taken-for-granted behaviors that groups rely on to create shared meaning in interaction (see Sidnell & Stivers, 2012). Throughout the dissertation, I refer to patient disclosures of medical misdeeds (Bergen & Stivers, 2013). This collection is not based on an analyst's or professional's distinction between medically healthy and unhealthy behaviors. Rather, inclusion criteria involved whether there is evidence of consensus between *doctor and patient* that the disclosed behavior would not be considered medically advisable.

Evidence of this consensus must be present either immediately before, during, or shortly after the disclosure turn. Patient-side evidence included, among other things, accounts, minimizations, qualifications, hesitancy or delay, orientation towards future change, negative assessments, and agreement with physicians' negative assessments. Physician-side evidence included, among other things, recommendations for behavior change, orientation towards an alternative behavior as 'better', negative assessments, and agreement with patients' negative assessments.

In some extracts shown in the chapters that follow, there is not an immediate patient orientation towards the disclosed behavior as problematic. However, in all cases, consensus was evident shortly after the disclosure if not during. For example, a patient might provide a one-word response to a physician's inquiry about exercise. However, upon physician acknowledgement of

the behavior, the patient might display an orientation to the behavior as problematic. I include these cases in my collection because my interest lies in patient orientations to fault and accountability in the disclosure turn, including minimal or no acknowledgement of fault and accountability in the disclosure turn.

Disclosure turns vary significantly across cases. Types of behavior disclosed range from eating too much Halloween candy, to smoking cigarettes, to being hospitalized after not taking medications for heart palpitations. I examine a wide range of cases, with an understanding that the potential risks or outcomes of the behavior will shape a physician's response while at the same time observing significant commonalities between a seemingly wide range of disclosures. To be clear, this collection excludes cases in which the patient does not treat the behavior as medically problematic; i.e., cases in which no disclosure occurs. This would also encompass cases in which the patient resists physician implication that the behavior is problematic.

I include both patient-initiated and physician-initiated disclosures (see Bergen & Stivers, 2013). Physician-initiated disclosures occur in response to physician solicitation of information. Patient-initiated disclosures are produced independently, without physician solicitation, often in first position.

1.6 Overview of the Dissertation

1.6.1 Chapter Two

Following the disclosure of a medically problematic health behavior, such as lack of exercise or smoking, a physician's next turn will be hearable as responsive to that admission. Physicians respond in a variety of ways to patient disclosure, from accepting or normalizing the patient's behavior, to negatively assessing the behavior or advising behavior change. Advising behavior change, however, can be a socially hazardous move. Chapter 2 examines physicians'

behavior change advice and patients' response to this advice. I show that physicians take two primary approaches to advising behavior change and that patients respond differently to these two forms of advice.

In just over half of advice sequences, physicians produce *treatment-implicative advice* that appeals to the project of establishing a treatment plan. In these cases, the physician frames behavior-change as an intervention aimed at addressing a specific health issue such as diabetes or rising blood pressure. Though all advice is clinically rooted in preventing or controlling medical conditions, making this link explicit provides a basis for patients to accept the physician's advice, ultimately rooted in the physician's epistemic primacy over best-practice treatment. In just under half of advice sequences, the physician produces overt, unvarnished advice that is not framed as treatment-relevant. This *straight advice* appeals to a moral order of patienthood – that a person must follow a healthy lifestyle to be a good patient. I examine regularities in patient responses to these two forms of advice and I find that the framing of advice is associated with clear regularities in patient response. Moreover, there is no clear association between patient response and categories of advice (e.g., extent of the behavior, type of behavior, objective relationship to medical condition).

Chapter 2 asks whether and when patients treat their doctors as having the right to supervise lifestyle and enforce lifestyle change. I compare patient responses to of lifestyle advice and patient responses to pharmaceutical treatment recommendations, and discuss the implications for our understanding of physicians' deontic status in the healthcare consultation as it relates to patients' home health behaviors.

1.6.2 Chapter Three

When a patient discloses medically problematic behavior, they rarely make a straight factual assertion. Self-presentation and framing of behavior are an inevitable part of the social reality of disclosure. This often overlooked aspect of disclosure is particularly relevant in a comparative context, when examining differences in when and how patients disclose medically problematic behaviors in medical settings that service low-income communities of color (Lowell and Lowry) versus high-income white communities (Highland and Hinsdale)

I begin Chapter 3 with an examination of physicians' encoded presuppositions and expectations about patients' behavior. I demonstrate that when physicians solicit information about patients' health behaviors, they presuppose medically problematic behavior more often in Lowell and Lowry, compared to Highland and Hinsdale. Next, I examine how patients frame their behaviors and when patients display a willingness to disclose. I find that in Lowell and Lowry, patients' disclosures display an orientation towards positive self-presentation. In contrast, patients in Highland and Hinsdale frequently upgrade their disclosures, emphasizing the extent or frequency of their behavior. Moreover, these patients display a high level of entitlement to use their disclosures to pursue projects such as negotiating treatment. Finally, I work to address seeming discrepancies between major sociological theoretical frameworks, including Cultural Health Capital (Shim 2010), and the findings presented here. I discuss how re-framing these discrepancies can help reveal the unique relevance of activity and action ascription in promoting dialogue between conversation analytic research and other sociological theories.

1.6.3 Chapter Four

Intuitively, we might not expect the reporting of routine medical test results (e.g., blood pressure) to be coupled with discussions of lifestyle. However, I show that the actual enactment of reporting medically problematic test results is not just incidentally, but systematically, tied to

discussions of health behaviors. An example of this would be the coupling of high blood pressure and lack of exercise, or high LDL cholesterol and nonadherence to cholesterol medications. In Chapter 4, I examine the etiology and treatment discussions that systematically follow reports of problematic lab results, and I explore how physicians and patients manage explicit and implicit attributions of fault in this context.

I begin by examining cases in which the physician orients to the patient's past behavior as potentially contributing to their medically problematic test result. Counterintuitively, patients orient to this context as *uniquely fitted* for expanded discussions of problematic health behaviors. Though they treat their disclosures as accountable, they frequently initiate disclosure in this context and expand on the disclosure with details about the circumstances surrounding their behavior. I then compare these disclosures to those made in contexts in which the patient's behavior is *not* linked to medically problematic health outcomes.

This dissertation demonstrates that disclosures of medically problematic behavior are not the delicate tasks that we might imagine them to be. Patients display a willingness to disclose following bad news, they emphasize their disclosures and use them to fish for treatment or diagnosis, and they are uniquely open to receiving lifestyle advice following disclosure. Disclosures are complex, as are the activities that surround them. How patients approach disclosure varies across communities. The findings presented in this dissertation help shed light on how mundane disclosures of medically problematic behavior, such as lack of exercise, fit into the contemporary healthcare consultation. In the new age of chronic care and medical surveillance, these findings reveal a social reality in which physician authority over patient lifestyle is highly conditional – it is not accepted on a basis of physician authority over *wellness*, but still on a basis of physician authority over *treatment*.

CHAPTER TWO

LIFESTYLE ADVICE: A SITE OF CONDITIONAL AUTHORITY

1.1 Introduction

With an increasing dependence on evidence-based medicine in our healthcare systems (Timmermans & Mauck 2005; Timmermans & Kolker 2004; Mykhalovskiy & Weir 2004) and studies establishing significant links between lifestyle and health outcomes (Schroeder 2007; McGinnis et al 2002; US Department of Health and Human Services 2014; US Burden of Disease Collaborators 2013), communities are in debate about where to draw the line between promoting population health and recognizing individual autonomy over lifestyle. We've seen public outcry against companies refusing to hire smokers (Leonhardt 2009), against bans on the sales of sugary drinks (Godoy & Aubrey 2013), and against increasing insurance premiums for overweight employees who don't join fitness programs (McGee 2015).

Arguably however, where the real battle is being waged – where lines are drawn, enacted, accepted and negotiated – is far more mundane. This line is drawn each time a medical professional makes a bid to supervise or direct a patient's lifestyle decisions. The line is erased and redrawn each time a patient resists a physician's lifestyle directive and accounts for that resistance. This chapter asks whether and when individuals treat doctors as having the right to supervise and enforce a lifestyle change.

Following a disclosure of a medically problematic behavior (e.g., admitting to smoking or not exercising), a doctor may advise a patient to change their behavior. This advice takes two forms in these data. This advice may appeal to the project of establishing a treatment plan; to address a specific health concern, one must pursue behavior change. The advice may alternatively appeal to

a moral order of patienthood; to be a good patient, one should follow a healthy lifestyle irrespective of a present diagnosis or treatment. This chapter analyzes these two forms of advice in order to expose how modern physicians and patients orient to the line between promoting population health and recognizing individual autonomy over lifestyle in the routine medical consultation.

1.2 Background

Public interest in promoting healthy lifestyle is pervasive. The global wellness market is growing nearly twice as fast as the global economy, with people spending over 4.2 trillion US dollars annually on wellness commodities including healthy eating, fitness and preventive medicine products (Global Wellness Institute 2018). In a survey of eating habits across 60 countries, half of respondents reported actively trying to lose weight (Nielsen 2015). Almost 70% of American smokers report wanting to quit smoking, with over 50% making at least one attempt to quit during the year (Babb et al 2017).

Modern Americans encounter an excess of information about healthy lifestyle. Over 80% of adults report hearing conflicting information about nutrition; the majority of this group reported experiencing heightened stress while shopping for groceries (IFIC 2018). Doctors can be trusted sources of information about health behaviors. Among individuals who recalled receiving information about nutrition from their doctors, 78% reported changing their eating habits as a result of physician advice in their lifetime (IFIC 2018). In turn, doctors consider discussions about lifestyle an important component of providing primary care services (Arborelius et al 1992).

In this environment, we might expect patients to be eager to receive lifestyle counseling and doctors eager to give it. Instead, contemporary primary care providers perceive significant social-interactional barriers to discussing lifestyle, including patient resistance and perceived lack of patient motivation, knowledge and insight (Jansink et al 2010; Lambe & Collins 2010).

Physicians report pessimism about patients' willingness to accept lifestyle change advice and patients' abilities to change their lifestyles (Orleans et al 1985). Lifestyle discussions occur in only 53% of primary care consultations in the United States, and just over half of these discussions result in lifestyle counseling (Russell & Roter 2011). While physician-patient discussions of smoking and physical activity have increased somewhat since the 1970's, there are no clear trends in discussions of nutrition or alcohol use (Noordman, Verhaak & van Dulmen 2010). These discussions are also largely physician-initiated and directed towards older men (Russell & Roter 2011; Noordman, Verhaak & van Dulmen 2010).

From a healthcare perspective, not following healthy lifestyle practices produces considerable medical and financial burdens (Goodchild, Nargis & d'Espaignet 2018; DiMatteo, Haskard-Zolnierrek & Martin 2012; Scarborough et al 2011). From a patient perspective, participation in healthy lifestyle behaviors is a matter of personal priorities and mitigating circumstances, as opposed to a simple adherence-nonadherence assessment (Donovan & Blake, 1992; Pound et al, 2005). As people interact with healthcare systems, these disparate interpretations collide – one interpretation of healthy lifestyle as protocol for being a *good patient*, the other interpretation of healthy lifestyle as part of a larger balancing act.

Healthcare organizations have increasingly moved to supervise peoples' everyday behaviors as a part of promoting preventive health agendas (e.g., Kanter 2013). Physicians themselves also claim increasing rights to supervise all aspects of a person's behavior that may relate to health – Sociologists have used the term surveillance medicine to describe this tendency (Zola 1983; Conrad & Walsh 1992; Armstrong 1995). Under surveillance medicine, a person's body is understood as a set of risk factors (Armstrong, 1995). Sociologists have studied increasing physician supervision of and influence over, for example, fitness (Wheatley 2005; Crawford 1980)

and alcohol use (Schneider 1978). Modern conceptualizations of morality have expanded to include individual responsibility for lifestyle behaviors that are associated with poor health (Becker 1986).

The process of medicalization has also become central to the field of medical Sociology (Conrad 2007) and has secured footing in public health (Metzl & Herzig 2007), bioethics (Parens 2011) and even popular culture (e.g., Khullar 2018). While the medicalization of patients' circumstances "turns the moral into the medical," surveillance medicine turns "health into the moral" (Conrad 1992, 1987). The processes of medical surveillance and medicalization are intertwined at the micro-social level. For example, increasing medical surveillance of sleep as a healthy lifestyle practice promotes the medicalization of sleep through physician supervision of sleep and increased prescribing of sleeping pills (Hislop & Arber 2003).

There is evidence at an organizational level that lay interests transform the landscape of medicalization and can promote medicalization of certain social and behavioral concerns (Conrad & Schneider 1980). This suggests medicalization is a social process as opposed to a fully top-down process (Strong 1979). However, studies examining how individuals respond to physicians' attempts to supervise lifestyle behaviors – the social process of surveillance medicine – are limited. Public health research on communications-based lifestyle interventions have not differentiated to what extent patient resistance to physicians' lifestyle advice is due to resistance towards *behavior change* itself versus resistance towards this flavor of *institutional control and intervention*.

The field of Conversation Analysis recognizes a micro-level moral order that is "cut from the same cloth as other forms of moral reasoning" (Stivers, Mondada & Steensig 2011). Micro-level moral calibrations are continually made in social interaction, relating to deontic rights, epistemic rights, affiliation and action types. Through this lens, a microanalysis of physician

attempts to supervise patient lifestyle reveals the state of modern surveillance medicine and patient orientations towards the moralization of lifestyle in the routine healthcare setting.

Advice-giving has been established as a fraught business across professional settings as diverse as HIV/AIDS pre-test counseling sessions (Kinnell & Maynard 1996), first-time mothers' well checks (Heritage & Sefi 1992), even peer tutoring in educational settings (Waring 2005). Resistance to advice is even common in everyday talk. Asynchronous or sequentially premature advice often garners resistance, and there is evidence this may in part stem from a broader resistance towards the shifting of interactional roles from troubles-teller and troubles-recipient to advice-giver and advice-recipient (Jefferson & Lee 1981).

In sensitive healthcare settings such as psychotherapy, healthcare providers can expect patients to "resist their actions and institutional agendas." (Vehviläinen 2008:120). Examining clients' resistance to therapists' proposals for behavior change in Cognitive Behavioral Therapy sessions for individuals with depression, Ekberg and LeCouteur (2015) find that clients typically respond to behavior-change proposals with active resistance. This resistance is characterized by accounts that allow patients to assert an inability to accept the proposal.

Patients also resist physicians' institutional agendas in other ways. In another study of patient resistance to a therapist's bids to discuss feelings, the authors identify withdrawal of cooperation as a major interactional resource, including non-uptake of aspects of a prior turn and managing or rejecting topic shifts (Madill, Widdicombe & Barkham 2001). Patients rarely resist therapist's attributions of their medically unexplained symptoms with straightforward rejection, but rather resist by dropping, refuting or undermining the physician's claim (Burbaum et al, 2010). Even children do not simply reject physicians' agendas, but take a more nuanced approach. One study of children's resistance to family therapists' agendas found that children typically used active

disengagement, expressions of autonomy, and passive resistance to disengage from the therapeutic process (O'Reilly & Kiyimba 2012). Sustained client resistance to the professional agenda may also result in a more oppositional orientation from the professional, more explicit forms of disengagement from the client, and ultimately a breakdown of progressivity (e.g., see Muntigl 2013 on couples counseling consultations). Professionals have a wide variety of practices they draw on to address individuals' resistance to advice. Professionals also sometimes soften the asymmetry of advice by producing advice-implicative interrogatives, orienting to individuals' epistemic authority over the circumstances of their own lives (Butler et al 2010).

Deontic authority has been defined as a person's rights to direct others' future actions. Social actions such as directives, announcements, and proposals communicate a speaker's orientation towards relative deontic authority (Stevanovic & Peräkylä 2012) which can be positioned at various strengths along a gradient (Stevanovic 2013). The negotiation of deontic authority in institutional settings, including healthcare, has been studied extensively by conversation analysts (Lindström & Weatherall 2015; Dalby Landmark, Gulbrandsen & Svennevig 2015; Stevanovic & Peräkylä 2012, 2014). By pursuing patients' commitment to a specific treatment plan or treatment option, physicians orient to patients' deontic rights over their own bodies and health behaviors (Dalby Landmark, Gulbrandsen & Svennevig 2015). This is also reflected in the progressivity of a healthcare consultation being contingent on patient's acceptance of a treatment recommendation (Stivers 2005, 2006). *How* a physician presents treatment options (e.g., recommendation versus option listing) also establishes a deontic gradient (Toerien, Shaw & Reuber 2013).

Beyond first actions that can communicate a deontic gradient, responses to these actions can resist, negotiate, or accept the deontic gradient. It has even been argued that deontic "authority

is not primarily about someone *claiming* authority, but it is about others *accepting* someone as an authority” though actions such as immediate acceptance of proposals and directives (Stevanovic 2013, p. 20). A deontic gradient between two individuals is also not static but rather highly dependent on context, to the extent that individuals’ relative ownership of the overarching interactional project can organize deontic authority (Rossi 2012).

The role of epistemic authority, or rights to knowledge, in physician-patient communication has also been studied extensively by conversation analysts (Maynard & Frankel 2006; Lindström & Wetherall 2015; Dalby Landmark, Gulbrandsen & Svennevig 2015; Lindström & Karlsson 2016). Entitlement to knowledge may be based on first-hand experience or reports (Pomerantz 1984), or on social identities (Heritage & Raymond 2005). Where patients claim primary rights to knowledge of the illness experience, physicians typically claim primary rights to knowledge of diagnosis and prescribing (Heritage 2006, Heritage & Robinson 2006, Peräkylä 1998, 2002). However, territories of knowledge are not as clear-cut as might be expected. For example, with increasing patient access to healthcare information, patients are seen to mobilize medical knowledge to resist treatment proposals (Lindström & Wetherall 2015). Physicians and patients also orient to an accountability to provide an evidential basis of certain types of diagnostic claims (Peräkylä 1998; Lehtinen 2006).

Failing to fulfil epistemic obligations can prompt individuals to hold one another accountable, “policing knowledge” (Sidnell 2005). An example of this is failing to follow the social norm that one should not inform others of things they already know (Goodwin 1979, Sacks 1992: 441). In this context, speakers may assert access to knowledge to combat the other’s claim of epistemic primacy. However, people not only have primary rights to certain types of knowledge, but responsibilities to hold certain types of knowledge (Pomerantz 1980). For example, an adult

patient has a responsibility to know that smoking is unhealthy. As such, people have responsibilities to avoid producing certain actions within certain epistemic contexts (Stivers, Mondada & Steensig 2011), for example a physician’s responsibility to avoid *informing* an adult patient that smoking is unhealthy.

In this chapter I examine physician advice after a patient admits to medically problematic behavior. I show that patients treat a physician’s deontic authority to supervise their lifestyle as conditional, and largely dependent on the approach the physician takes to advising behavior change – namely, whether the advice is framed as a *treatment for a medical condition* or not. As I will show in this chapter, the extent to which patients grant physicians this authority or resist their agenda is interactionally dependent. In what follows, I offer support for these claims.

1.3 Data

This study is based on a primary collection of 48 instances in which, following a patient’s disclosure of a medically problematic behavior, a physician advises the patient to make some related change such as adjusting their diet, exercise or smoking. See Chapter 1 for details on the dataset and inclusion criteria for the original collection of 83 patient disclosures of medically problematic behaviors. I use the term “behavior-change advice” to refer to all directives, requests, suggestions, assertions, pronouncements and other explicit bids for behavior change that reference the disclosed behavior. Cases 1-4 illustrate some of the forms that such behavior-change advice can take. For instance, an upgraded imperative is used in Case 1.

Case I
Behavior Change Advice: Cigarette Smoking
1 Doc: You really should quit.

In Case 2, the physician provides a personalized and upgraded suggestion.

Case II
Behavior Change Advice: High Levels of Alcohol Consumption
1 Doc: So .hh uhm I would definitely try to cut that back.

In Case 3, the advice is formatted as a request for information, but carries the force of a request for action.

Case III

Behavior Change Advice: Not Drinking Enough Water

1 Doc: Can you force yourself to drink?

Finally, in Case 4, the physician's advice is a mitigated non-personal suggestion.

Case IV

Behavior Change Advice: Medication Nonadherence

1 Doc: ((nod)) Probably be a good idea to take i:t,

A constitutive feature of the collection is that the physician explicitly directs the patient to make a change related to the disclosed problematic behavior. Advice not related to the disclosure was not included. Similarly, the collection does not include instances in which a physician only *implicitly* advises behavior change, for example through a negative assessment of the disclosed behavior (e.g., Oh that's not so good).

Besides considerations of form, behavior-change advice also occurs in different positions in the consultation. In these data, advice sometimes occurs immediately following the disclosure and other times we see it later in the consultation, for example during the treatment recommendation or even the closing phase of the visit. Behavior-change advice from all phases of the visit are included in the collection so long as they reference a specific behavior disclosed earlier in the consultation.

Finally, in building the collection I observed that sometimes physicians advise behavior change multiple times. Because these seem to be working to secure patient acceptance of the advice, I included all instances of advice.

1.4 Analysis

Advice for behavior change is a fraught business. Physicians sometimes ask patients to alter deeply ingrained habits. Despite the fact that much of the advice may not be welcome, there are clear regularities in the relationship between how the advice is provided and how it is responded to. Relying on aspects of both *position* and *formulation* of behavior-change advice, I show that when the physician's behavior-change advice is recognizable as *treatment for a medical condition*, patients typically accept the recommendation immediately. Conversely, when a physician produces unvarnished, *straight lifestyle advice* without a clearly articulated relationship between the advice and a medical diagnosis, patients commonly resist the project of promoting future behavior change (i.e., rejection, blocking accounts, displays of prior knowledge).

I begin by identifying key differences between treatment-implicative lifestyle advice and straight lifestyle advice. I offer evidence that when physicians frame behavior-change as a treatment for a medical condition this promotes patient acceptance. When they produce straight lifestyle advice without conveying its treatment relevance, patients are more likely to resist. This analysis suggests that the reason for this difference does not lie with the type of behavior change being recommended but with the framing. Specifically, I argue that *establishing a treatment regimen* is treated as a unique context in which physicians have additional leeway to discuss sensitive topics and push the limits of what would typically be considered their deontic authority. In contrast, straight lifestyle advice invokes a moral order of patienthood. I offer three main types of evidence for this claim. First, I provide a detailed qualitative analysis of the position and formulation of physicians' advice and types of patient response. Next, I examine regularities in rates of patient acceptance of advice when physicians do versus don't frame behavior change as a treatment for a medical condition. Finally, I examine deviant cases and instances in which advice is reformulated.

1.4.1 Constructing Behavior-Change as a Treatment

In Case 1, the patient discloses not exercising and the physician advises that he exercise. She frames exercise as a treatment for the patient's high blood pressure. In these data, advising exercise is the most common form of behavior-change counseling. As the transcript opens, the physician is formulating a treatment plan for the patient's high blood pressure, which has remained above healthy levels despite prescription medication for over a year. The behavior-change advice occurs at lines 42-43.

Case 1

```
1 Doc: I think we need to add one more, ((referring to medication))
2 Pat: I (.) think (.) that's fine.
3 Doc: .hh U:::m. And then I th^ink tha:t if m- if next time we're
4 still not at a good- where we wa:nt, .hh I'm gonna send you
5 to cardiology,
6 Pat: Okay.
7 Doc: A- And just make sure we're not missing something else.
8 (0.5)
9 Doc: that's going on.
10 Pat: Okay, cause like- um: I'm okay taking whatever medications
11 [they are?
12 Doc: [Mhm?
13 Pat: I don't- (1.0) I changed my diet significantly: over the last
14 year,
... ((discuss patient's diet, doctor positively assesses))
31 Pat: The thing that I: (.) haven't been able to do: is my ah w-
32 workout routine has just gotten (0.3) disappeared essentially
33 [at this point?
34 Doc: [Oh::.. okay.
35 Pat: And I used to be like (0.8) beyond extremely active, for
36 [most of my life? So I don't know if that's: a con[tributing
37 Doc: [Mmmm. [Yes?
38 Pat: factor,
39 Doc: Mm hmm?
40 Pat: So it's.
41 Doc: Yeah I mean your weight is fi:ne, You're totally at a normal
42 weight,=But definitely exercise, and being: conditioned? is
43 gonna- is gonna help you.
44 Pat: Okay,
```

At line 1 the physician makes a treatment recommendation, a pronouncement-type recommendation for an additional prescription medication to treat the patient's high blood pressure

(Stivers & Barnes 2018). The patient accepts (line 2). The physician then makes a conditional pronouncement-type treatment recommendation, a contingency plan (Mangione-Smith et al 2001) for specialist care (lines 3-5/7/9), which the patient accepts (line 10). Across lines 1-10, patient and physician participate in a project of establishing a treatment plan for the patient's high blood pressure. The patient then expands this project into his next turns, linking his next action with "cause", reiterating his acceptance of the treatment recommendation and beginning to describe recent changes to his diet (lines 13-14). Following the patient's description of his diet and the physician's positive assessments of his diet changes (transcript not shown), the patient builds a contrastive disclosure, admitting that he has not been exercising (lines 31-33). The patient then states that he does not know whether his lack of exercise is a "contributing factor" to his high blood pressure. In this context, the K- assertion is hearable as a bid for information (Heritage 2012). In response, the physician advises behavior change.

The advice at lines 41-43 for "exercise and being: conditioned" is formulated as an assertion (see Stivers et al 2018). The physician states that exercise "is gonna help you" (line 42), which in this context is hearable as *help you improve your blood pressure*. The position in which the advice occurs, as well as the formulation of the advice itself, makes the physician's turn at lines 41-43 recognizable as *treatment* for the patient's under-controlled high blood pressure. The physician even takes it one step further, preempting a potential (mis)understanding of the recommendation as relating to the patient's weight or general health by prefacing the confirming recommendation for exercise with the statement that the patient is "totally at a normal weight" (lines 41-42). At line 44, the patient accepts the advice with "Okay" (Stivers 2005, 2006). Physician and patient then go on to discuss options for where and how the patient could begin exercising (transcript not shown).

A similar case is found in Case 2 involving is a mother of two toddlers, receiving treatment for post-partum depression. She has come to the consultation wearing full exercise attire, seemingly after exercising. Aside from the post-partum depression, the patient has no other chronic health concerns. However, she presents with an acute issue – pain in the nipple, which she attributes to stopping breastfeeding. The physician instead diagnoses a yeast infection (transcript not shown). The physician’s behavior change advice occurs at lines 13-14.

Case 2

1 Doc: Yeah I would treat that for yeast. Cause the nipple .hh
 2 Pat: Oh [okay.
 3 Doc: [um can get moist.=The other is just to open to air.
 4 (0.8)
 5 Pat: O:[kay.
 6 Doc: [Cause yeast can’t gro:w (.) in oxygen. So it could be in
 7 the bra: it’s ti:ght, or after sweating:,
 8 Pat: Oh from (0.4) working o::ut.=
 9 Doc: =Ri:ght. I don’t know if you keep the same bra: for a long
 10 time? or do you usually just go shower after:,
 11 Pat: Uh:m (.) not immediately, sometimes I have to go run get my
 12 kids [and then come ho:me, so,
 13 Doc: [Ri:ght. Like a while,=**So ideally you would change out**
 14 **of anything wet.**
 15 Pat: Oh: Okay. Okay.
 16 Doc: **Or air. [You know. So if you’re home later in the day maybe**
 17 Pat: [O::h=okay,
 18 Doc: **you can go without a bra:?**
 19 Pat: Oh:.

At line 1, the physician makes a pronouncement-type unspecified treatment recommendation for pharmaceuticals to treat a yeast infection. The patient accepts the physician’s initial treatment recommendation at line 2. The physician builds her next TCU at line 3 as a part of a list, expanding the project of establishing a treatment plan for the patient’s yeast infection into her next turns. She builds *opening the infection to air* as a relevant step to addressing the yeast infection then describes the mechanism through which this can treat the infection (line 6). She then explicitly attributes the source of infection to wearing a tight and sweaty sports bra. As we saw in Case 1, the physician establishes a patient behavior as a contributing factor to a health issue.

However, in this case, the disclosure is associated with fewer long-term health risks (wearing dirty workout clothes versus not exercising), and the health issue cited is acute (treating a yeast infection versus chronic (long term high blood pressure)). In addition, this is all done *prior* to disclosure, and it is only after the physician establishes the potential patient behavior as a contributing factor that the physician solicits patient disclosure and advises behavior change.

The physician can see that the patient is wearing exercise attire and a sports bra, but she nonetheless solicits disclosure at lines 9-10. The patient reports that she doesn't shower or change immediately after exercising (line 12), and the physician displays her understanding of the disclosure by reformulating this as for "a while" after exercising (line 13). The physician then asserts that the patient would "ideally" change out of her wet athletic clothes immediately after exercising (lines 13-14). The physician continues to suggest that the patient go completely without a bra when in the privacy of her own home (lines 16/18). The behavior-change advice is formulated as an assertion-type treatment recommendation followed by a suggestion-type treatment recommendation for the patient to expose the infection to air and avoid wearing damp clothing. As established by the physician at line 5, this would prevent the yeast from growing. As we saw in Case 1, the patient immediately accepts the physician's advice at lines 15 and 17.

Although directly linking behavior-change advice to a medical diagnosis is common, physicians also provide behavior change advice in positions where the physician makes no clear or direct connection to a medical diagnosis. In these cases, the advice is not treatment implicative, but rather formulated as straight lifestyle advice. In Case 3, a patient discloses not exercising (like Case 1), and the physician advises that the patient begin exercising (again, like Case 1). The patient in Case 3 has diabetes and high cholesterol, but unlike Cases 1-2, the physician does not draw a clear connection between these diagnoses and her behavior-change advice at lines 37-38.

Case 3

1 Doc: Okay. So we [have to- ((closes chart))
 2 Pat: [How my sugar level and thing like that.
 3 Doc: ((nod)) Your sugars:, ((opens chart))
 4 Pat: It's oka:y?
 5 (1.0)
 6 Pat: I like to keep check on that.
 7 Doc: Yes your sugars are oka:y? ((closes chart, stands up))
 8 Pat: Mm hmm.
 9 Doc: Mm hmm.
 10 Doc: .hhh Yeah so how's your diet.
 ... ((discuss diet, physician recommends smaller meals))
 31 Doc: So are you (.) um exercising?
 32 Pat: No:.
 33 Doc: Okay.
 34 Pat: Lazy.
 35 Doc: Ye(h)h ((laughs))
 36 Pat: ((laughs))
 37 Doc: **But I think- I know it's co:ld right now but maybe you can**
 38 **increase the walks: during the da: [y?=
 39 Pat: [((shakes head))
 40 Doc: =Do you- are you working?
 41 Pat: No. Can't walk,
 42 Doc: You can't walk,
 43 Pat: Due to my knee. I have bad knee.
 44 Doc: O:::h=Okay. And [then-
 45 Pat: [And when I walk, Ohy. Painful.**

The patient in Case 2 is visiting the physician for a routine chronic-care checkup. Prior to line 1, the physician has reviewed the patient's labs and reported some issues with cholesterol and potassium levels (transcript not shown). She has already recommended the patient begin taking her prescribed medications for high cholesterol and low potassium (the patient was taking neither), and when she closes the chart, the physician marks a shift in her agenda away from the lab report. As begins to stand up, the patient asks how her blood sugar has been. The physician gives a no-problem response, reporting that they are "oka:y" (lines 4/7). The physician then closes the chart, stands up, and places the chart on the counter.

In this context, the physician's next inquiry is set apart from what came prior in terms of her body position (standing rather than sitting), the activity (no longer reviewing with the chart), and with the design of the question – a request for a report of the patient's diet at line 9. The so-

preface marks the question as “emerging from incipency” and separate from what came before (Bolden 2009). In addition, rather than another declarative question in a series, we have a shift in format to “How’s your diet” treating this as starting a distinct agenda in the visit and thus not part of a broader project of establishing etiology for a health concern or establishing a treatment plan for a health concern, but is rather hearable as a routine history-taking question as part of a chronic-care checkup. The physician recommends the patient eat smaller meals and more vegetables (transcript not shown), and then the physician moves on to another common chronic-routine history-taking question – whether the patient is exercising (line 31).

The patient discloses that she is not exercising and self-deprecatingly accounts for this with her comment that she is “lazy” (lines 32/34/36). The physician’s behavior-change advice comes at lines 37-38. She acknowledges an alternative candidate account for the patient’s lack of exercise (the weather) and suggests that the patient do more walking during the day. Critically though, this advice is not linked to any particular diagnosis nor to a health outcome, as we saw in Case 1. Instead, it is delivered as general health advice. This communicates moral order of patienthood; to be a good patient, one ought to exercise, irrespective of a diagnosis or treatment process. The physician’s recommendation asserts deontic authority to determine the patient’s exercise habits without reference to any specific diagnosis or treatment – based only on her authority as physician. The response of this patient to the physician’s advice to exercise is very different from the response of the patient in Case 1. Here, the patient immediately rejects the advice (line 39) and provides a blocking account – that she “can’t walk” due to pain in her knee (lines 41/43/45).

Although it may seem intuitive that behavior-change that is closely linked to a health condition (e.g., hygienic practices and yeast infection) would be more likely to be framed as treatment, this is not the case. Instances of straight lifestyle advice range from advising adhering

to medication regimens to following up with specialists to reducing alcohol consumption following a diagnosis of liver disease. Furthermore, in every instance in which a physician advises behavior change in these data, that advice *could have* been linked in some way to a problematic health outcome (e.g., rising blood pressure) or diagnosis (e.g., hypertension). Next, I present Case 4, in which the physician advises the patient to take his previously prescribed medication but without formulating the behavior-change as treatment.

The patient in Case 4 has booked an appointment to discuss a shoulder injury. When the consultation opens, the physician and patient greet each other (transcript not shown), and the physician opens the chart and notes that he hasn't seen the patient in two years (line 3). This patient was previously diagnosed with high blood pressure. The behavior-change advice occurs at lines 36-37.

Case 4

1 Doc: Wo:w. (.) Yea:h.
 2 (1.5)
 3 Doc: >I guess I< haven't seen you in two years.
 4 (2.0)
 5 Doc: Ri:ght? ((gaze to patient))
 6 Pat: Been two years,
 7 Doc: ((gaze to chart)) .hhhh khh khh ((coughs)) According
 8 to this:: it was: ah September two thousand thirteen:: .hhh
 9 (2.0)
 10 Doc: And you're: (0.2) on:: (2.0) This ri:ght ankle, your-
 11 Hypertension::, (1.8) So:: you:'ve bee:n (.) out of your
 12 ((gaze to pat)) blood pressure medicines ((gaze to chart))
 13 for that (0.3) long,
 14 (0.8)
 15 Pat: No. ((head shake))
 16 (3.0)
 17 Doc: ((head shake))|(2.0)
 18 Doc: I didn:'t (0.5) see any refills,=S:o you're g- how're you
 19 getting ((gaze to patient)) refills.
 20 Pat: My wife just ca:lls CVS and they re fill 'em. .hhh
 21 (0.4)
 22 Doc: ((writes in chart)) Ohkay. ((nod))
 23 Pat: .hhhhh hhh ((loud sigh)) / (1.5)
 24 Doc: Have you been takin' em recently::, or you been ((gaze to
 25 patient)) missin'. (0.3) m[issin' some of em.
 26 Pat: [I've been missing em.

27 Doc: ((writes in chart)) Okay.
 28 Pat: .hhhh off and on,
 29 (0.3)
 30 Pat: I've been (0.5) dealing with other issues.
 31 (5.0)
 32 Doc: You still have em?
 33 Pat: .hhh Yeah.= [hhh
 34 Doc: = [Okay. Alright. ((nod))
 35 (0.5)
 36 Doc: .hhh khh khkh ((coughs)) ((gaze to patient)) **Well I would**
 37 **suggest that you <take em,>**
 38 (1.0)
 39 Pat: ((nod)) Yeah. [(I know.)
 40 Doc: [Otherwise you'll have other problems. that
 41 ahm:, may not be reversible.
 42 Pat: ((small nod)) °Yeah.°
 43 Doc: ((writes in chart)) / (12.0)

At lines 7-13 the physician cites evidence that the patient has not seen him in over two years and asks if the patient has run out of his blood pressure medications. The patient denies this at line 15, and the physician provides further evidence that the patient has in fact run out at line 18. After an additional round of resistance, the physician continues to pursue patient disclosure, re-formulating his question to ask whether the patient has been missing his medications. The physician's repeated disclosure solicitations are hearable as stemming from the refill dates listed in the chart – not the patient's actual blood pressure readings. The patient provides a mitigated disclosure of medication nonadherence (lines 26/28) and an account followed by silence (lines 30-31).

At lines 36-37, the physician turns around, looks directly at the patient, and prefaces his advice with “Well” – a common marker of disagreement or disaffiliation (Heritage, 2015; Pomerantz, 1984). Then, instead of directing the patient to take his medications, the physician informs the patient that *he would suggest* he take his prescribed medications. The physician builds his advice as a reminder for the patient to do something he already knows he should be doing – in other words, he builds his advice as a correction of a problem which implies a failing

on the part of the patient. Despite the physician advising medication adherence (something closely tied to a known health condition), the physician does not *frame* behavior-change as a treatment plan. At no point does he invoke the patient's high blood pressure in his solicitation of disclosure or behavior-change advice.

We might think that the connection to blood pressure is obvious, so patients would not discriminate in the framing, but this is not what we see. Rather, as in Case 3, the physicians in Case 4 appeals to a moral order of patienthood. To be a good patient, a person must take their medications, irrespective of the specific diagnosis or treatment plan. His assertion also demonstrates a deontic authority to enforce medication compliance without reference to the diagnosis or treatment plan, based solely on his authority as physician.

Like other patients receiving advice without a direct connection to treatment, the patient in Case 4 is resistant. He does not respond to the advice for a full second, then provides minimal agreement and a display of prior knowledge (line 39). Silence and displays of prior knowledge are indicators of disaffiliation and disalignment in social interaction (Stivers, Mondada & Steensig 2011; Stivers 2008). They are also common responses to physician advice formulated as sanctions in these data. The physician then goes on to justify his advice by citing the risks of continuing to *not* take the medication (lines 40-41). Notably, the physician does not invoke the patient's diagnosed high blood pressure here either – instead, he simply threatens “other problems”, an indirect reference to the patient's earlier account of “other issues” (line 30) for not taking his medications. The patient very quietly agrees and twelve seconds of silence follow.

1.4.2 Overview of Patient Responses to Behavior-Change Advice

I argue that straight lifestyle advice conveys a moral failing to follow the protocol of *being a good patient*, and it is for this reason that we would expect patients to systematically respond to

straight lifestyle advice with non-acceptance. Thus, our next question is whether the rate of patient acceptance varies across treatment-formulated versus straight lifestyle advice. Consistent with Stivers & Barnes (2018) and Bergen et al (2018), I draw on Stivers' (2005, 2006) definition of treatment acceptance to identify cases in which the patient immediately accepts physician advice. Patient acceptance (e.g., *okay*, *alright*, *I will*) is distinct from agreement (*yeah*), acknowledgement (*mmm*), and displays of prior knowledge (*I know*), which are understood as passive resistance in the treatment recommendation context (Stivers 2005, 2006). Table 1 displays the rates at which patients immediately accept versus do not immediately accept treatment-formulated versus straight lifestyle advice. The rate of immediate patient acceptance is considerably higher (72% versus 17%) when the physician's advice is treatment-formulated. This suggests that patients find it problematic to be told what to do when this advice is not framed as an intervention to treat a medical condition (e.g., hypertension) or medical concern (e.g., rising blood pressure) and are thus more resistant. Yet, when directly tied the same type of advice to a health condition, patients were more willing to accept advice when it is given as.

	Immediate Acceptance	No Immediate Acceptance
Treatment-Formulated Lifestyle Advice	72% (18)	28% (7)
Straight Lifestyle Advice	17% (4)	83% (19)

Table 1: Patient response to treatment-formulated versus sanctioning advice

Conversely, a few cases of straight lifestyle advice were accepted, and a few cases treatment-formulated lifestyle advice were resisted. One account for these departures may simply be that some patients are generally more adherent (those who are inclined to accept anything the physician advises) while others may be more independent or hostile to particular types of advice

(those who resist even treatment-implicative advice). Still, in the cases in which patients respond with immediate acceptance to straight lifestyle advice, two of the four cases involve the only instances in the data set in which physicians advise patients to get preventive cancer screenings after patients disclose that they did not follow prior advice to do so. Both instances are produced as straight lifestyle advice, yet patients immediately accept the physician's advice in both instances. There are also a number of regularities across cases in which the patient does not immediately accept treatment-formulated advice. These are discussed in detail in further analytic sections below.

Turning to rates of acceptance of treatment-formulated advice, we can see from Table 2 that rates of patient acceptance of treatment-formulated behavior change advice are higher than rates of patient acceptance of prescription and over-the-counter treatment recommendations more generally. Comparing primary care physicians' recommendations for prescription and over-the-counter interventions for health conditions (from Bergen et al 2018) to primary care physicians' recommendations for behavioral interventions for health conditions in this dataset, we find that American patients are most likely to immediately accept behavioral interventions (72%), followed by prescription interventions (43%), and that they are least likely to immediately accept over-the-counter interventions (31%). We can also note that the rate of immediate acceptance of behavior change advice with no treatment formulation is lower than that for all three types of health interventions (17%).

	Immediate Acceptance	No Immediate Acceptance
Treatment-Formulated Behavior Change Advice	72%	28%

Treatment Recommendation for Prescription Medication <i>(From Bergen et al 2018)</i>	43%	57%
Treatment Recommendation for Over-the-Counter Medication <i>(From Bergen et al 2018)</i>	31%	69%
Straight Lifestyle Advice	17%	83%

Table 2: Patient response to recommendations for over-the counter, prescription, and behavioral interventions

These findings provide evidence that patients generally discriminate between treatment-formulated lifestyle advice and straight lifestyle advice. Treatment-formulated advice for behavior change has a very high rate of patient acceptance – higher even than recommendations for pharmaceutical treatments.

1.4.3 Patient Orientations to Advice Formulations

In the previous two sections, I have shown how patients respond to the treatment formulated and straight lifestyle advice. I have also documented the robustness of this pattern. I proposed an account for this difference: that treatment-formulated advice builds into the recommendation a diagnostic account for complying with the advice, whereas straight lifestyle advice relies solely on a moral account for complying. In this section, I pursue these different accounts for advice in an effort to better understand what underlies patients' differential uptake of the advice.

In Case 5, the patient has scheduled an appointment to go over routine bloodwork. The patient has had high cholesterol for many years despite prescription treatment. She is also taking medication for high blood pressure and experiences pain and weakness in her legs. Earlier in the consultation, the patient disclosed not taking her cholesterol medication or potassium supplements. The physician has just finished reviewing the lab results and finishes reviewing the rest of the

patient's chart at lines 1/3. The physician's first round of behavior-change advice occurs at lines 5/7.

Case 5

1 Doc: Oh you just had a phys[ical].
2 Pat: [I jus had a phys[ical]:.
3 Doc: [Okay.
4 (2.0)
5 Doc: Alright, .hh So: um We have [to- hh **You have to take your**
6 Pat: [So-
7 Doc: **medicines. every da:y. Tha[t's important,**
8 Pat: [And le:ave the e:ggs alo:ne, [and
9 Doc: [Yes.
10 Pat: but I don't bother with e:gg, or cheese, anything.
11 Doc: Ok[ay. And fri:ed food.
12 Pat: [I'll take my potassium.
13 Doc: **Take your potassium, and take your cholesterol medicine.**
14 Pat: °Ye::h.°
15 Doc: **Okay? .h And umm:**
16 (1.8)
17 Doc: **Yeah you should be taking all of your medicines every day.**
18 Pat: ((slow nod)) | (1.0)
19 Doc: **Oka::y?**
20 Pat: I- I ta:ke my blood pressure medicine,
21 Doc: Ah huh,
22 Pat: But that [cholesterol-
23 Doc: [Do you have a pi:ll [box? How come you don't- .hh
24 Pat: [((laughs)) Ye::s, I ha:ve.
25 Doc: How come you don't like the cholesterol medicine.
26 (1.5)
27 Pat: You know why:, [Superstitious. I listen to people say-
28 Doc: [Why.
29 Pat: You take tha::t, it will damage your li:ver::, and your
30 ki:dney: and that's why I- ((laughs))
31 Doc: Ah. But [if you don't-
32 Pat: [>You know.< Telling the truth.
33 Doc: Okay, But if you don't take it. [It's gonna do more damage.
34 Pat: [Mm.
35 Doc: Because you have your blood vessel like thi:s? ((gesture))
36 And then the cholesterol builds and builds and builds and
37 then your blood vessels ((gesture)) get clogged.
38 Pat: Mhm. ((nod))
39 Doc: And that leads to heart attack, chest pa:in, problems with
40 your legs,
41 Pat: Mhm,
42 Doc: Um numbness: weakness:, Problems with the blood flow.
43 Pat: I will take it.
44 Doc: Oka:y, [Yeah. So it's worse to not take the med[icines.
45 Pat: [Mhmm,
46 Pat: Okay.=

47 Doc: =We really need to get that under control.
48 Pat: I will. I wi:ll, ((nod))

Following the sequence-closing third (line 3) (Schegloff 2007) and two seconds of silence (line 4) the physician directs the patient to take her prescribed medications every day (lines 5/7) and emphasizes the importance of medication adherence (line 7). As we saw in Case 4, although the physician is advising medication adherence, she does not frame behavior-change as a treatment. She does not invoke the patient's high cholesterol in her behavior-change advice, but rather simply asserts her advice. The advice appeals to a moral order – a good patient should take their medications “every da:y”. The patient orients to this bid to moral order in her response, listing another behavior-change recommendation the physician made earlier in the consultation, to “le:ave the e:ggs alo:ne” (line 8), and then emphasizing that this is something she already does (line 10), thereby emphasizing behaviors that make her a *good patient*. She then commits to taking her potassium supplements (line 12).

The physician then specifically directs the patient to take her cholesterol medication (line 14). Again, the physician does not frame the advice in terms of the patient's *high cholesterol* but rather appeals to a moral order of patienthood. Following a minimal, quiet agreement the physician adds a tag question, pursuing patient acceptance (line 15). And following a full second of silence, the physician *again* directs the patient to take her medications (line 17) and adds another tag question pursuing acceptance (line 19), still without invoking the patient's high cholesterol. Following the physician's fifth pursuit of acceptance at line 19, the patient actively resists the physician's advice (line 20). She begins by emphasizing that she *does* take her blood pressure medications as prescribed, and indicates some trouble with the cholesterol medications. At line 25, the physician alters her approach and asks the patient why she doesn't like the cholesterol medication.

The patient answers that she has heard the medication can damage the liver and kidneys (lines 27/29-30). However, instead of addressing the patient's concerns directly by providing information about medication side effects, the physician explains what untreated high cholesterol does to the body (lines 35-37). She then lists the impacts cholesterol buildup can have on the body in lay terms (lines 39-40/42) including weakness and problems with the legs, both of which the patient is currently experiencing. In effect, the physician explains what the cholesterol medication is treating, thereby giving medication adherence *treatment relevance* in terms that are directly relevant to the patient. Instead of appealing to a moral order of patienthood, as we saw at lines 5/7/13/17, here, the physician appeals to the project of justifying her advice as part of a treatment plan. To address a specific health concern (weakness and problems with the legs, among other things) the patient must institute behavior change. The patient first commits to behavior change at line 43. The physician's behavior change advice ("We really need to get that under control") is formulated as an assertion-type treatment recommendation (Stivers & Barnes 2018). Her claim to deontic authority to enforce medication adherence is based on an established epistemic authority over treatment options. The patient immediately accepts, repeating her commitment to behavior change twice (line 48).

As we saw in Case 5, once the physician has linked the health behavior to the potential negative health outcome, patients are more likely to accept the advice and orient to the advice as treatment-relevant. This helps to document what patients understand to be different in the two types of advice. It also underscores the fact that it is not simply that a link is made explicit but that they understand the link. The fact that patients challenge these links is thus further evidence that patients orient to *constructions of behavior-change as treatment* as interactionally distinct from any moralizing of their behavior. We see another instance of patient challenge in Case 6 in which

the patient does not accept the physician's advice until it is explicitly re-formulated as a treatment recommendation. However, the context that surrounds the reformulation of the advice is very different for Case 6.

This patient has presented with ringing in her ears. The physician is in the middle of history-taking and is getting ready to transition into the physical exam. The first round of advice occurs at lines 14-16 and the second round of advice occurs at lines 83/85.

Case 6

1 Doc: I'm gonna peek in your ears if you don't mind, .hh u:hmm most
2 common causes of ri[nging in the ear:s ((laughs))
3 Pat: [Well alri:ght, ((laughs))
4 Doc: .hhh Most common causes o:f ringing in the ears, Have your-
5 Has your caffeine level changed at all?
6 Pat: No, I [drink a lot of caffeine.
7 Doc: [No,
8 Doc: That can do it.
9 Pat: But I've a:lways drank a lot of caff[eine.
10 Doc: [Yea::h but you know
11 whatever, a little bit co:ld little bit thi:s like something
12 changes in your body, .hh <Caffeine can make it worse.>
13 (0.8)
14 Doc: **.h So I'm not saying cut out caffeine a h- hundred percent**
15 **cold turkey, because that would prolly make you feel really**
16 **crappy but .hhhh**
17 Pat: Well I could (.) see if it is the caffeine [by cutting it
18 Doc: [Yea:h. ((nod))
19 Pat: o:ut, (Really,)
20 Doc: The other thing:, Um. (1.0) Aspirin,=Do you take Aspirin?
... ((continue discussion, physical exam))
80 Doc: The couple things I'd d- do, .h I will:: um: Bioflavonoids,
81 Which [is a vitamin? Over the counter? I would start that,
82 [((nod))
83 Doc: **I would try to .h cu:rb the caffeine if you [ca:n a little**
84 Pat: [((nod))
85 Doc: **bit,**
86 Pat: Oka:y,

The physician solicits a report of caffeine intake during the history-taking phase as she pursues the project of establishing etiology and diagnosis. The physician indicates that an increase in caffeine can cause ringing in the ears (lines 4-5). She asks whether the patient's caffeine level has changed, including the negative polarity marker "at all" (Heritage 2010), treating "No" as the

preferred answer. The patient provides a confirming “No.” but then volunteers that she drinks “a lot” of caffeine (line 6), thus modifying the presupposition of the physician’s question that she did not but might have increased caffeine intake. The physician indicates that this “can” cause ringing in the ears. The patient, however, orients to the discrepancy between the physician’s initial request for information (line 5) and her candidate etiology (line 8) by countering that her caffeine level has not changed (line 9). In this way, the patient treats the legitimacy of the link between the behavior and the health issue as relevant even before the physician begins to give behavior-change advice.

The physician has not performed the physical exam, so she does not yet have a full picture of what the diagnosis and treatment will entail. She gives a pre-recommendation for behavior change at lines 14-16. Having established the legitimacy of the link between caffeine and ringing in the ears, the patient proposes that she could “see if it is the caffeine” by cutting her caffeine intake. The key point here is that this is not a *commitment to behavior change*, but rather a proposal for it – which the physician and patient have not yet agreed to and will come back to later in the consultation, *after* the physical exam and diagnosis.

The physician then performs the physical exam and informs the patient that she is not experiencing an ear infection or earwax blockage, which would have involved alternative treatment regimens. The physician instead diagnoses age-related hearing loss which can cause tinnitus (ringing of the ears) and be aggravated by caffeine, among other things (transcript not shown). The physician transitions into the treatment-recommendation phase of the visit, first recommending a vitamin to treat the tinnitus, then recommending the patient “cu:rb the caffeine” to treat the tinnitus. Once framed as a treatment recommendation, the patient immediately accepts the physician’s advice at line 86.

1.4.4 Advice Solicitation in Treatment-Relevant Contexts

The analyses of Case 5 and Case 6 provide evidence that constructing behavior-change as a treatment for a medical condition promotes patient acceptance whereas straight lifestyle advice engenders resistance. I have begun to argue that what underlies the different uptake has little to do with the content of the advice being given (e.g., exercise or medication adherence) but has instead to do with the implied basis for the behavior-change recommendation. Although all recommendations for behavior-change in these data are clinically rooted in avoiding or controlling medical issues such as diabetes, hypertension, or high cholesterol, making this link *explicit* indicates to patients why they should comply with the advice. Furthermore, physicians' deontic authority over determining the patient's lifestyle is rooted in an established epistemic authority over treatment of disease. When this link is not made explicit, the advice may convey the patient's failure to follow the protocol of being a good patient – a moral order of patienthood. It also leaves physicians' deontic authority over patient lifestyle to be rooted in institutional authority alone.

Further support for this can be found through examining cases in which patients go so far as to *pursue* an overt link between the advice and the treatment plan. Patients do not pursue behavior-change advice that is couched as a moral failing. Rather, they recognize the project of establishing a treatment plan as a unique context in which sensitive discussions and high-entitlement directives are not treated as problematic.

In Case 7, the patient presented with heart palpitations and, after physical exam and history-taking, the physician has begun to lay out a treatment plan. She recommends that the patient stop taking her multivitamin (transcript not shown) and then asks the patient to write down when the heart palpitations occur (lines 1-2). The physician's advice to stop smoking occurs at lines 16-

17/19. The patient had successfully quit smoking for two years after using the smoking cessation medication Chantix, but discloses that she recently re-started (line 11).

Case 7

1 Doc: But (0.5) we can try that first,=And then if you could write
2 do::wn, when it happens:, and what you[re doing.
3 Pat: [It's It's in there at
4 different ti:mes. Sometimes I'm .h you know (.) laying there
5 reading:, or watching TV.=I mean it'll just start, You know,
6 Doc: Ye[ah.
7 Pat: [and then I'll take a few deep breaths, and .hh I'll get
8 into be:d, and it'll still be there:, [and just relax
9 Doc: [Yeah.
10 Pat: and it stops and it's not there in the morning. I don't
11 know what causes it. [But I mean I'm smoking 'n it's like
12 Doc: [Yea:h.
13 Pat: well you know y- you're giving yourself shots of nicotine:,
14 Doc: You're still smoking?
15 Pat: Yeah:. Will you [help me stop smoking:,
16 Doc: [Gotta stop that.
17 Doc: **Yea:h. You gotta stop that for sure.**
18 ((patient nods)) / (1.0)
19 Doc: **That could be it,**
20 (0.5)
21 Pat: I'm wondering if I should go back on the Chantix.
22 ((referring to smoking cessation medication))

At lines 1-2, the physician is recognizably pursuing the project of establishing a treatment plan for the patient's heart palpitations. The patient informs the physician that she has not noticed any direct correlation between the heart palpitations and external factors (lines 4-5/7-8/10). In this way, the patient orients to an understanding of the physician's prior turn as part of a larger agenda to establish etiology and a treatment plan for the palpitations. At lines 10-11 the patient makes this explicit, stating that she doesn't know what causes the palpitations. However, as part of the same turn she then contrasts her claim not to know the cause with the disclosure that she is smoking (lines 11). The following TCU "And it's like well you know y- you're giving yourself shots of nicotine;" (lines 11/13) presents one part of an internal dialogue with the patient. The "Well" preface (Heritage 2015) presents this as responsive to the earlier "I don't know what causes it." In this way the disclosure is understandable by the physician as offering a solution to this puzzle.

At line 14, the physician requests confirmation that the patient is still smoking. Requesting confirmation of something that has just been said commonly indicates something problematic with the prior turn and works to solicit an account (Raymond & Stivers 2016; also see Robinson & Kevoe-Feldman 2010). At line 15, the patient confirms that she is currently smoking, with no downgrade or mitigation but also no account. Having just proposed that the smoking could be causing her heart palpitations, she makes a bid for help quitting smoking (line 15). The physician then comes in in overlap with behavior-change advice, “Gotta stop that” (line 16). This is followed by “gotta stop that for sure” (line 17). The physician does not explicitly link the advice at line 16 to the diagnosis of heart palpitations. Despite the patient’s just prior bid for support in quitting smoking, she responds to the physician’s advice to quit with passive resistance including silence and nodding but nothing else (line 18).

The physician explicitly invokes the diagnosis at line 19 - “That could be it”, meaning that the smoking could be causing the heart palpitations. By line 19, the physician’s advice is now clearly recognizable as a treatment plan for the patient’s heart palpitations. The physician’s directives lay claim to a deontic authority to determine the patient’s smoking behavior *insofar as* behavior change is a viable treatment plan to address the patient’s heart palpitations. At line 21, in direct response to the physician’s advice, the patient proposes going back on the smoking cessation medication Chantix. By formulating her proposal as “I’m wondering”, the patient positions herself as *having already been* considering methods to quit (Tietbohl 2017). Ultimately, the patient and physician discuss smoking cessation medication options and the patient leaves the visit with a prescription in hand, having accepted the recommendation to quit smoking. Critical for our analysis here is that this happens after the physician makes the link between the medical problem

and the smoking clear, something that the patient appeared to be in search of as she had articulated a search for help at line 15.

Case 7 provides evidence that patients orient to the project of *establishing a treatment plan* as a unique context in which patients pursuing behavior-change advice and physicians making recommendations for behavior change are treated as non-problematic. Further evidence for this claim can be found across the dataset. For example, returning to Case 1, the patient similarly pursues a treatment via behavior change after disclosing that he is not exercising shortly after the physician initiates treatment negotiation (lines 31-33). He even goes so far as to explicitly ask the doctor if his lack of exercise could be a contributing factor to his high blood pressure (lines 35-36). Thus, patients appear open to lifestyle advice that they understand is directly linked to ongoing health conditions and will even actively seek this link if it is not forthcoming.

Another type of evidence that patients are more receptive to lifestyle advice when linked to a diagnosis than when this is not the case, is that they may explicitly request clarification of whether advice is a treatment recommendation if the primary action is not clearly recognizable. For instance, in Case 8, the patient has booked a follow-up consultation with a primary care provider after visiting Urgent Care and being diagnosed with a urinary tract infection. The physician has taken a urine test to determine whether the antibiotics prescribed by the Urgent Care are the best choice for this infection. As the transcript opens, the physician is informing the patient that her staff will call her if any change in her prescription treatment is indicated. The behavior-change advice occurs at lines 25/27.

Case 8

1 Doc: We'll follow it up [an:d .hh and take care of that so that's
2 Pat: [Okay.
3 Doc: not a problem.=But you're feeling fine, [.hh Do you think
4 Pat: [Yeah,
5 Doc: it was like not drinking enough water::?

6 [Or do you think it wa[:s
7 Pat: [.hh Well I- [Honestly I don't drink enough [water.
8 Doc: [Okay.
9 Pat: I- I know that for a fa[ct.
10 Doc: [Yeah.
... ((discuss drinking coffee))
17 Doc: [Yeah. Yeah. .hh See I
18 don't like water myse:lf? so I'll do: like I'll- I'll put
19 like a green tea bag really lightly: in just (.) cold, .h
20 Pat: Yeah.
21 Doc: Or like Crystal Li[:ght? Or like I'll do something to it to
22 Pat: [Yeah.
23 Doc: make it- cause I don't like water [either. ((shrug))
24 Pat: [Yeah. ((laughs))
25 Doc: **So: But you gotta.=It's good for your [body and especially**
26 Pat: [Yeah.
27 Doc: **now that you've had a [UTI?**
28 Pat: [Yeah. ((nod))
29 (0.8)
30 Doc: So [um:
31 Pat: [So my- So that would be the- the best way to
32 Doc: Yea:h.
33 Pat: prevent it ri:ght,
34 Doc: Yeah yeah.

At lines 3-5/6 the physician asks the patient whether she thinks “not drinking enough water::” could have caused the urinary tract infection (UTI). The patient and physician had not discussed water earlier in the consultation. In response, the patient discloses that she doesn’t drink enough water (lines 7/9). The physician then discusses how coffee can affect hydration (transcript not shown) and then reports what she does to help make drinking water easier for her (lines 18-19/21/24). The patient agrees and laughs (lines 20/22/24).

At line 25, the physician advises behavior change with “you gotta”. The account that follows is first a moral one “It’s good for your body” but the turn does not stop there. The doctor then explicitly invokes the UTI and the possibility of recurrence before reformulating a directive for the patient to drink more water. Because of the formulation of the turn, it is unclear whether the basis of the physician’s advice lies in the general moral order of maintaining healthy lifestyle

(“It’s good for your body”) or whether it lies in behavior change being a viable treatment to prevent recurrence (“now that you’ve had a UTI?”).

The patient agrees with the physician’s advice (line 28), but then comes in in overlap with the physician’s next turn to request clarification of whether the advice was given as a *treatment recommendation for prevention of UTI recurrence*. ‘So’ prefaced turns such as these pursue an agenda that was already ‘on the speaker’s mind’ across the prior turns at talk (Bolden, 2009). This ‘so’ prefaced request for confirmation provides further evidence that the patient considered *establishing a treatment plan* her primary agenda across this sequence. The physician confirms at lines 32/34.

As compared to Cases 1 and 7, Case 8 provides a slightly different form of evidence that patients orient to the project of *establishing a treatment plan* as a unique context in which disclosures, discussion and advice surrounding health behaviors is treated as routine and non-problematic. Like the patients in Case 1 and Case 7, the patient in Case 8 initiates disclosure in a treatment-relevant context and even upgrades the severity of her disclosure. Uniquely, however, the patient requests confirmation that the advice is *treatment relevant* when the physician does not recognizably formulate her advice as a treatment recommendation.

1.4.5 Patient Resistance to Advice that Invokes Treatment

The analysis above has established that patients distinguish between behavior-change advice that is part of a project of *establishing a treatment plan* and advice that is not, with patients frequently resisting advice that does not invoke treatment of a known health condition. However, as established in the quantitative analysis, patients still resist treatment-formulated advice in almost 30% of cases. This motivates a question of whether patient *resistance* to advice looks different in response to treatment-formulated versus straight lifestyle advice. Furthermore, is there evidence

that patients are resistant not only to the advice itself, but to the physician's *project of promoting behavior-change* in one or both categories of advice? In Case 9, the patient is resistant to a physician's advice, when that advice invokes treatment of a health condition. Case 9 is suggestive of another layer of understanding for the pattern in these data: patients are willing to participate in the project of establishing a treatment plan and promoting behavior-change *even if* they are resistant to some aspect of the physician's advice – when that advice is framed as a treatment plan to address a health issue.

As Case 9 opens, the patient topicalizes her weight. Key, however, is that she makes her weight *treatment-relevant* by reporting that she's considering bariatric surgery (lines 1-2). In this context, she initiates disclosure of a “bad” eating habit – eating her wife's leftovers (line 9). Her wife recently underwent bariatric surgery herself and is eating less. The physician's first round of advice occurs at lines 18-21, and her second round of advice occurs at lines 26/28-29/31-32.

Case 9

1 Pat: I mean I've been thinking about um (.) the: the bariatric
 2 [surgery,
 3 Doc: [Ye^a:h.
 4 Pat: Cause it's like- Ma::n. I've gotta protect myself. ((laugh))
 5 Doc: ((laugh))
 6 Pat: I- I started a ne:w bad habit,
 7 Doc: Uh oh what (.) 's the new bad habit.
 8 (1.5) ((patient mimes eating))
 9 Pat: °Eating Kelsey's leftovers.°
 10 Doc: Oh:::: no:[::::.
 11 Pat: [°It's ba:d.°
 12 Pat: It's like. So I stopped doing it. It's like I didn't
 13 realize I was doing it it's like ((gasp)) °I'm eating her
 14 left[overs.°
 15 Doc: [Because she's fu:ll,=
 16 Pat: =Yeah she's full. and it's like (.) Yeah that looks good,
 17 ((mimes eating))
 18 Doc: **So she needs to also take le:ss, so that she: realizes that**
 19 **she doesn't need to eat that much because she's not hungry**
 20 **.h so that it doesn't become a leftover and then .h**
 21 **[y- hh ((short laugh))**
 22 Pat: [Well this was mostly when we go o:ut.
 23 Doc: Oh it's when [you go o:ut. [Okay. Okay.
 24 Pat: [Yeh: [Yeah: so it's like ugh:.

25 So it's [like-
 26 Doc: **[But she could- she can take that portion ho:me,**
 27 Pat: Ye[h?
 28 Doc: **[Or: sometimes what people do now? .h is: they just**
 29 **before you even get your food.**
 30 Pat: Oh you- Yeah you put it in.=
 31 Doc: **=You tell them to put half of it into a container to go**
 32 **home.**
 33 Pat: Mkay. (.) But yeah:. I started I was like ((gasp)) °No.
 34 Gotta stop that.°
 35 Doc: Yeah.
 36 Pat: Was like Oh: Why^ don't we split something. They're not-
 37 (.) Takes care of it.
 38 Doc: If you split something that's even better?
 39 Pat: Yeah.

The physician orients to the behavior as problematic (line 7) and negatively assesses it (line 10). At lines 9-10, the patient provides an account for the behavior, and reports that she's since stopped the behavior, implying that permanent behavior change is the end-goal. However, the pre-announcement at line 3 and the account at lines 9-10 indicate the possibility of a relapse into this eating in the future.

The physician advises promoting a change in the wife's eating behavior to support the patient's eating habits (lines 18-21). However, the advice presupposes that the patient is eating her wife's leftovers at home and the wife therefore has the option to "take le:ss", or plate smaller portions. The patient comes in in overlap at line 22 with a correction of the presupposition. Notably, though the patient does not accept the physician's advice at line 22, she is actively participating in the project of promoting behavior change by providing additional information about her behavior and correcting the physician's presupposition. Although this response pushes back against the physician's first round of advice as only occasionally relevant, it provides a space for the physician to further pursue a discussion regarding her eating behavior. Importantly, it does not resist the physician's broader project of promoting behavior-change, but rather engages with it.

The physician provides a second round of advice starting at line 19, addressing how the patient's wife could order at restaurants to better support the patient's eating habits. As the physician presents her advice, the patient shows significant engagement, finishing the physician's sentence at line 30, accepting the recommendation at line 33, and presenting similar advice she gave her partner previously at lines 36-37. In line 38 the physician advises splitting meals in line with the patient's own thought which avoids leftovers coming home to be eaten at all.

In contrast to Case 9, patient responses to straight lifestyle advice do not indicate participation in an underlying project of promoting behavior-change. For example, a review of patient responses to Case 3 and Case 4 reveals that rejection, displays of prior knowledge, and minimal agreement with silence (disengagement), are the range of responses we tend to see to this advice. This holds true throughout the dataset – we can see this as well in Case 10.

Case 10 provides an example of a patient countering as a form of active resistance – this is another type of patient resistance we see in response to straight lifestyle advice, but we do not see in response to treatment-formulated advice. The patient was recently checked into the emergency room (ER) after experiencing heart palpitations. The patient booked this consultation as a follow-up to his visit to the ER. Just prior to this transcript, the physician has been picking up the patient's various pill bottles and shaking them to determine whether there are pills inside. The patient has disclosed that he ran out of his medication for heart palpitations and his medication for high cholesterol (transcript not shown). As the transcript opens, the physician shakes the bottle of blood pressure medications and finds the bottle is empty. The behavior-change advice occurs at lines 4-5.

Case 10

```
1 Doc: Ah: How bout the blood pressure me:ds, You all out of that,  
2 (1.0) | ((doctor reads pill bottle))  
3 Pat: Uh[m
```

4 Doc: [You know it's usually a good idea to try to call before
 5 you run o:ut,
 6 Pat: Oh yeah.
 7 Doc: And .hh you know (.) Th- These are the kind of thi:ngs that,
 8 (1.0) | ((doctor turns gaze to patient))
 9 Pat: Right.
 10 Doc: you know get you in the emergency room.
 11 Pat: Emer- Yeah. .hh But I mean- you know- Usually though: Dr.
 12 Miller I I I try to stay on it though. Cause I already know
 13 I ain't tryna: be out here: you know: (.) killing myself or
 14 stuff like that. Cause I- [I be kin-
 15 Doc: [Well you gotta slow down
 16 partying. A little bit.

The physician's solicitation of disclosure (line 1) is not built within a broader project of establishing a treatment plan for a diagnosis, but rather it is built within a broader project of determining which prescription medications the patient is and is not taking. The physician then advises the patient to call the office and request a refill before he runs out of his medications in the future (lines 4-5). The physician does not invoke a diagnosis and frames his advice as a reminder ("You know it's usually a good idea"). In other words, the physician explicitly orients to this as *something the patient already knows to do* and thereby formulates the advice as a reminder. The physician also prefaces his next turn with "you know", this time reminding the patient that this type of behavior gets you "in the emergency room." (lines 7/10).

In response, the patient emphasizes that he tries to "stay on" his medications (lines 11-12). This counters the physician's implied assessment of the patient as nonadherent and thereby resists the very basis of the physician's advice. The patient then states that he's not trying to kill himself, again undercutting the legitimacy and relevance of the physician's advice. Unlike the patient resistance in Case 9 and Case 10, the patient's resistance in Case 11 does not participate in the broader project of promoting behavior change, but rather resists the basis of that project.

1.4.6 Patient Responses to Cross-Cutting Formulation and Position

At this point, I have argued that patients are more receptive to advice, both in terms of willingness to commit to behavior change and willingness to engage in the project of promoting behavior change, when it is formulated as a treatment plan than when it is offered without this formulation. I have illustrated cases to document this receptivity as well as having documented that patients orient to the two types of advice differently with a clear preference for the latter, treatment-implicative type. I have argued that when physicians do not formulate the advice as a treatment plan, the advice becomes a moral issue – an issue of following healthy lifestyle *irrespective of any health condition* – and that patients tend to resist this both in terms of resistance to the advice and resistance to the project of promoting behavior change.

In this section, I draw on two more cases in which behavior-change is only partially constructed as a treatment for a health condition – the position or the formulation indicates a treatment recommendation, but not both – and therefore the advice is not necessarily recognizable as treatment-relevant. I show that, in these cases, patients’ resistance reflects what they see as problematic *about* the framing of the advice. I examine how these reflections indirectly display preference for advice framed as a treatment recommendation.

The patient in Case 11 is visiting the physician for a routine wellness check. As the transcript opens, the physician is in the middle of correcting the family history in the chart and checking on the patient’s home health behaviors, inputting all of this into the chart as she speaks. Just before the transcript begins the physician has asked the patient if she needs a referral for a mammogram, and the patient said yes. At line 1, the physician offers to give the patient the referral ahead of time, and the patient agrees. The physician then turns back to look at the chart and requests confirmation that the patient has never smoked (line 3). The quit-smoking advice occurs at line 25.

Case 11

1 Doc: Yeah but I’ll- I’ll give it to you so that you have it.

2 Pat: Yea:h.
 3 Doc: You've never smoked at all. right,
 4 (1.5)
 5 Pat: .hhh Ahh: no that's not true:.
 6 Doc: Oh you did smoke in the past,
 ... ((discuss how much patient smoked and currently smokes))
 21 Doc: Okay.=So it's just a:: (.) very uhm (0.5) small amount.
 22 Pat: Yea:h.
 23 Doc: Some day- (.) Okay.
 24 (2.0) ((doctor typing))
 25 Doc: **You really should quit. with your osteoporosis the way it is?**
 26 Pat: I know:. You told [me la:st time.
 27 Doc: [Ye:h.
 28 Pat: I to:ld you I do last time, and you said You have to work on
 29 that,=
 30 Doc: =Yeah:.
 31 (6.0) ((doctor typing))

The physician-initiated disclosure and subsequent talk about smoking is hearable as stemming from routine history-taking and the process of filling in the chart (lines 3-6). Once the physician has established how much the patient currently smokes (transcript not shown), she requests confirmation that it is a small amount (line 21) and silently types the patient's information into the chart for a full two seconds (line 24). Up to this point, there is no indication that the physician is pursuing the project of establishing a treatment plan. In other words, the position in which the advice takes place is not one of treatment relevance, but rather routine history-taking. At line 25, the physician provides her behavior-change advice "You really should quit." She then immediately cites the patient's osteoporosis as a *reason to comply* with her advice. This is done through the increment (see Ford, Fox & Thompson 2002). Though the physician invokes the patient's diagnosis of osteoporosis here, it is not done in a treatment-relevant position and therefore is hearable as a post-hoc justification for the advice, fitted to the patient's health history and not necessarily treated as new information.

The patient responds with immediate resistance. Importantly, her resistance signposts her primary complaint about the physician's advice – that it's something she already knows and thus

treats the advice as primarily indicating a failing on her part rather than an effort to treat a medical condition. In doing so, the patient is also resisting the physician's claim to authority to direct her behavior on the basis of an established epistemic authority over treatment options. The physician further orients to the patient's equal epistemic access to this advice when she simply agrees with the patient's complaint that she's already been told all of this (lines 27/30). Across lines 26 and 28-29, the patient repeatedly cites their equal epistemic footing as her primary complaint as she resists the physician's stop-smoking advice.

The analysis of Case 11 motivates a closer examination of patient resistance towards an opposite form of behavior-change advice – advice provided in a treatment-relevant position, but formulated as straight lifestyle advice. The patient in Case 12 presents joint pain. She has been previously diagnosed with arthritis despite being in her 30's. The physician's behavior-change advice occurs at lines 8-9. The case opens towards the beginning of the consultation, as the patient reports her primary health concerns.

Case 12

1 Pat: I always have pain in my joints,=Especially in my ha:nds?
2 .hh My left knee is bothering me a lo:t.
3 (1.0)
4 Pat: Uhm:,
5 (0.8)
6 Doc: Are you exercising,
7 Pat: Uhh:: I just do walking, I just [walk,
8 Doc: [No. Walking i- is good
9 but it's not exercise really. .hh You really need to exercise.
10 Pat: I just- I fee:l like (.) even walking sometimes is a lot. For
11 my left knee:, Like it just .h it always hu:rts.
12 Doc: Okay.

At lines 1-2, the patient reports that she has been experiencing joint pain in her hands and knee. Because she has been previously diagnosed with arthritis, the physician can move directly to establishing etiology and treatment recommendation while forgoing the diagnosis phase. The physician asks whether the patient is exercising, which in this context is hearable as linked to the

project of establishing etiology and a treatment plan. The patient discloses that she “just” walks (line 7), orienting to her exercise as insufficient and thereby opening a space for behavior-change advice formulated as a treatment recommendation.

However, the physician takes a different approach. She makes a no-prefaced positive assessment of walking, resisting the patient’s epistemic right to define walking as a form of exercise (Radclaw 2013). She states that walking is “not exercise really” (line 8). She then offers unvarnished, straight lifestyle advice, asserting “You really need to exercise” (lines 8-9). Though the earlier question (line 6) is hearable as relating to establishing a treatment plan, the advice is formulated as straight lifestyle advice. In this context, treatment-formulated advice could have looked something like “*I’d recommend more exercise. That should improve the pain in your joints*”. Despite the placement, the physician’s advice still appeals to a moral order of patienthood; to be a good patient one should exercise. The physician’s claim to deontic authority over the patient’s exercise regimen is based on institutional authority rather than epistemic authority over treatment options.

The patient responds with an account that largely blocks physician pursuit, citing external circumstances (pain) that prevent her from exercising. The patient in Case 12 works to undercut the implication that she has failed her duties as a *good patient* by citing external circumstances that prevent her from complying with physician advice. As we saw in the prior section, these forms of patient resistance have very real, negative impacts on what resources physicians can draw on to promote behavior change following these forms of patient resistance (see Case 3, Case 4, Case 11). Claims of prior knowledge and citing preventive external circumstances fundamentally challenge the underlying project of promoting behavior change.

2.5 Discussion

This study explores how primary care patients respond to physicians' bids to supervise or direct their lifestyle decisions. Patients do not uphold one consistent stance on a physician's right to enforce lifestyle change, as we saw in Case 5 and Case 6. Rather, the extent to which patients treat physicians' lifestyle advice as acceptable is largely determined by the way in which the physician frames the advice. Specifically, whether the physician frames the advice as a treatment recommendation, in which case the physician's deontic authority to enforce lifestyle change is rooted in an established epistemic authority over disease management. Or, whether the physician produces straight lifestyle advice, in which case the physician's deontic authority is rooted in a moral order of patienthood. While patients typically accept the former, they typically resist the latter. Moreover, what underlies the different uptake has to do with the implied basis of the behavior-change recommendation, as opposed to the type of behavior change recommended. Although all recommendations for behavior-change in these data could have been framed as an intervention to treat medical conditions such as diabetes, hypertension, or high cholesterol, making this link visible indicates to patients why they should comply with the advice.

When physicians frame behavior-change advice as a treatment plan, they remain well within the bounds of what is broadly considered the physician's realm of epistemic and deontic authority – treatment of disease. Interestingly, patients' rate of immediate acceptance of physicians' behavioral treatment recommendations is higher than the rate of immediate acceptance of pharmaceutical treatment recommendations. In this sense, patients show a high level of willingness to accept non-pharmaceutical treatment advice when it directly addresses a patient's disclosed health behaviors.

However, when physicians produce straight lifestyle advice, without a link to a diagnosis, physicians claim a deontic authority by appealing to a moral order of patienthood – to be a good

patient, a person should pursue a healthy lifestyle irrespective of any diagnosis or treatment. Patients do not just resist the physician's advice in this context, but also resist the *activity* of supervising and sanctioning. Case 4 provides an example in which the patient resists everything from the physician's solicitation of disclosure to his behavior-change advice. Case 3 provides an example in which the patient not only resists, but blocks the physician's advice trajectory.

This paper uncovers the modern patient's aversion to a 'moral order of patienthood' as a basis for lifestyle advice. It also reveals physicians' reliance on such advice – almost half of all instances of behavior-change advice are formulated as straight lifestyle advice (N=23 of 48). Although all advice in this collection is clinically rooted in avoiding or controlling medical conditions, building the advice as a treatment recommendation provides a further basis for the physician to claim the authority to advise lifestyle change. Patients show a social-interactional preference for treatment-formulated advice, as well as a high rate of acceptance when behavior-change is framed as a medical treatment.

CHAPTER 3

DISCLOSURE: A SITE OF DISPARITY

3.1 Introduction

Extensive research on disparities in treatment outcomes and provision of care shows clear evidence that the US healthcare system is deeply stratified by income, education, race and ethnicity (Smedley et al., 2003). People of color and individuals with a lower socioeconomic status are perceived by physicians as less intelligent and less adherent (van Ryn & Burke 2000; Lutfey & Ketcham 2005), receive a more directive-style of doctoring (Fiscella et al 2002; Willems et al 2005), and receive lower-quality treatment (Smedley, Stith & Nelson 2003; Lutfey et al 2008) compared to white and high SES individuals. So, it is not surprising that those with the greatest risk of receiving poor treatment also believe most strongly that positive self-presentation is important for getting the best medical care (Malat et al 2006).

This study examines a single interactional moment across a large and diverse sample of video-recorded healthcare consultations – the moment in which a patient discloses a medically problematic behavior such as medication nonadherence, smoking, or lack of exercise. Across Highland and Hinsdale, versus Lowell and Lowry, I examine physicians' enacted orientations to patients' lifestyle and the work patients do to present themselves as reasonable when disclosing a medically problematic health behavior. I ask whether the act of disclosure is different in high-income white communities versus low-income communities of color. I ask whether there is evidence that disadvantaged patients do additional work to present themselves as reasonable in the context of disclosure, and what this would reveal about patients' propensities to adjust micro-interactional behaviors to the stratification of our healthcare system. To answer these questions, I analyze physicians' encoded presuppositions and expectations about patients' behavior, patients'

framing of their initial report of behavior, and the contexts in which patients disclose problematic behavior.

3.2 Background

The healthcare consultation is a key site for the realization of health disparities. For example, it has been well established that social demographics factor into physicians' care allocation decisions (Lutfey et al, 2008). Patients with less than a high school education and non-white patients report the lowest levels of involvement in healthcare decisions, which will primarily be carried out in the home (Kaplan et al, 1995). Patients with high education receive more diagnostic and health information than others (Street, 1991), and those with lower education tend to receive a more directive style of doctoring, with less time spent on patient questions, negotiating, and counseling (Fiscella et al, 2002). Low-SES patients receive a less participatory consulting style in the healthcare visit generally (Willems et al, 2005).

Among other factors, physicians report making treatment recommendations based on assessments of patient cognitive ability, motivation, and social support (Lutfey et al, 2008). Such assessments are significantly associated with demographic factors such as race (Lutfey & Ketcham, 2005). Providers' assessments of patient intelligence and abilities is also significantly associated with patient race and socioeconomic status, respectively (van Ryn & Burke, 2000). One post-visit physician survey found that physicians perceived African American patients to be less intelligent and less likely to adhere to medical advice compared to white patients (Ryn & Burke 2000). The same study found that physicians' perceptions of desires, behaviors, and responsibilities varied across patient SES, with physicians perceiving low-SES patients as having less desire for an active lifestyle, less likelihood to participate in rehabilitation, and fewer caregiving responsibilities in the home.

In her work on cultural health capital, Janet Shim draws on Bourdieu's (1980, 1983) concept of cultural capital to conceptualize how interactional styles can be viewed as behavioral "resources" and are rewarded by physicians in clinical settings (Shim, 2010). She lays out a collection of interactional styles that constitute a patient's cultural health capital. Notably, this includes displaying a proactive stance towards health, a value of self-discipline, and knowledge of medical topics and vocabulary. Shim argues that certain patients are taught to *mobilize displays* of self-discipline and knowledge of medical vocabulary, which providers then respond to with a more patient-centered approach (Epstein et al., 2005). Addressing the concern of assigning fault to individual patients, Shim emphasizes that the ability for patients to acquire and mobilize these communicative resources is largely habitual, deriving from past experiences, and both arising from and contributing to social stratification.

When it comes to social-interactional work aimed at securing quality medical care, Malat et al (2006) show that African Americans and those with relatively low levels of education and income consider positive self-presentation more important to receiving quality care than whites and those with high levels of education and income. Essentially, individuals from disadvantaged backgrounds are more likely to treat quality medical care as conditional on their behavior during the consultation than those from privileged backgrounds. These authors examined patient ratings of the importance of self-presentation strategies including that they "be friendly with the doctor," "let the doctor know that you care about your health," and "show that you are an intelligent person." The authors state that these strategies "reflect a white, middle class standard" of self-presentation. Conceptually, this parallels Shim's theory of Cultural Health Capital but emphasizes patients' *awareness* of this process and their efforts to achieve a certain kind of self-presentation.

An examination of how self-presentation and mobilizing cultural health capital in the medical consultation plays out across low-income communities of color versus high-income white communities is well suited for a conversation analytic approach. The concept of self-presentation is embedded in the central lineage of Conversation Analysis (CA) and has been addressed in CA research on patients' problem presentations, candidate diagnoses and treatment negotiations.

Harold Garfinkel's (1967) influential study addressing gender and the role of self-presentation was followed a decade later by Erving Goffman's (1971) introduction of the dramaturgical model of social interaction. Goffman explored how we manage our behavior to shape how others view us, conceptualizing self-presentation as "an unavoidable feature of social life" (Heritage & Stivers 2013). As early as 1972 Harvey Sacks began analyzing the ways in which police infer moral character when interacting with the public. Sacks introduced the concept of *recipient design* in his lectures in the early 1970s (cf. Malone 1997: 100-119; Sacks 1992), a fundamental example of other-orientation in social interaction. Though Conversation Analysis has primarily focused on the role of self-presentation in institutional settings such as emergency call centers (Svennevig 2012), support groups (Simmons-Mackie & Elman 2010) and medical settings (Heritage & Robinson 2006), there has always been an underlying current of research on other-orientation in everyday social interaction – for example preference organization, accountability for action trajectories, conditional relevance, and the like (Schegloff, Jefferson & Sacks 1977; Pomerantz 1984; Peräkylä 1998; Stivers & Rossano 2010).

CA studies have established that self-presentation plays a major role in the routine medical consultation. Patients do considerable interactional work to present themselves as credible sources of information about symptoms, as opposed to drug-seekers or hypochondriacs (Heritage & Robinson 2006; Halkowski 2006). Among other things, patients go out of their way to indicate

that others urged them to seek care, that attempts at self-treatment have failed, and that they were not looking for symptoms but rather ‘noticed’ them. They do this work to achieve a ‘culturally appropriate’ balance between involvement and detachment in order to present themselves as reasonable and therefore their health concerns as clinically relevant. From the opposite perspective, there is also evidence that physicians do interactional work to uncover the patient’s level of credibility in identifying symptoms (Maltz 2019).

Patients also work to present themselves as reasonable when resisting physicians’ diagnoses (Peräkylä 2002, 2006; Gill 1998; Gill, Halkowski & Roberts 2001; Gill & Maynard 2006). For example, instead of rejecting a physician’s diagnosis outright, which is rare, patients typically report negative observations, or symptoms that are inconsistent with the physician’s diagnosis (Peräkylä 2002; Ijäs-Lakkio, Ruusuvuori & Peräkylä 2010). Patients also incorporate diagnosis-implicative symptoms and candidate diagnoses early in the consultation, before the physician is expected to provide a diagnosis (Stivers 2002). In treatment negotiation as well, patients work to avoid presenting themselves as drug-seeking. For example, even parents who present a candidate diagnosis of a bacterial infection rarely request antibiotics outright (Stivers 2002) and tend to approach the diagnosis with uncertainty (e.g., what they “think” the patient “might” have). Patients also couch bids for treatment within other activities and actions, such as disclosures of medical misdeeds (Bergen & Stivers 2013). However, despite a wealth of research on patients’ self-presentation in the healthcare consultation, we have yet to describe or understand the *differences* in the use of self-presentation practices across patient populations.

Patients’ use of interactional resources to present themselves as reasonable is intertwined with physicians’ orientations towards patients as (un)reasonable. This is observed in responsive physician sanctioning and rejection of lines of action perceived as, for example, medication

seeking (Stivers 2002). Examining turns that *prompt* the use of such interactional resources, however, is needed. Conversation analysts have explored the ways in which question design shapes politicians' next actions in political interviews. Distinguishing between *neutrality* and *neutralism*, Clayman & Heritage (2002) use the term neutralism to measure the extent to which a question is built to minimize presuppositions, preferences and agendas. Neutrality, or a freedom from bias, is functionally impossible when asking a question. Neutralism, meanwhile, can be conceptualized on a continuum, the other side of the continuum being adversarialness – a measure of the extent to which a question is built *with* encoded presuppositions, preferences and agendas that will shape the politician's ability to present themselves in a certain way (Heritage & Clayman 2011).

Presuppositions define the terms on which a response can be constructed (Clayman & Heritage 2002). By *not resisting* an encoded presupposition, a respondent tacitly accepts the presupposition when they answer the question. At least in political interviewing, it is not uncommon for such presuppositions to be face-threatening (Goffman 1955). Constructing a question to set a topical and action agenda (Clayman & Heritage 2002) goes hand in hand with the question's action and activity. Because questions are not always simply 'requests for information' but may also be 'doing history-taking' or 'pursuing disclosure', they set action agendas and topical agendas that the recipient must then either conform or not conform with.

In the clinical encounter, there is an interactional preference for polar questions designed to anticipate a medically preferred answer. This has been termed the principle of optimization (Boyd & Heritage 2006). However, there is one important exception: if there is evidence that the medically preferred answer isn't true. This is the principle of problem-attentive question design (Stivers 2007). Importantly, this means that if a physician does *not* build their question to anticipate the medically preferred answer, the question is hearable as problem-attentive, meaning the

physician is hearable as drawing on evidence from the patient or their medical record. In this way, the polarization of physician questions about patients' health behaviors can display a subtle orientation towards their understandings and expectations of patients' lifestyles.

This study uses conversation analysis to examine physicians' orientations towards patients' health behaviors when first soliciting a report of those health behaviors, as well as the resources patients use to present themselves as reasonable when disclosing medically problematic health behaviors. Across Highland and Hinsdale, Lowell and Lowry, I ask how the stratification of our healthcare system shapes patients' experiences with care providers, and how this stratification shapes patients' micro-interactional behaviors, when medically problematic health behaviors are discussed.

3.3 Data

As outlined in Chapter 1, the dataset was coded for all instances of patient disclosure of a potentially medically problematic behavior. Disclosures were not identified based on a professional's distinction between problematic and unproblematic health behaviors. Instead, they were based on evidence of consensus between physician and patient that the disclosed health behavior would not be considered medically advisable. All patient behaviors which physician and patient oriented to as medically problematic were included in the collection – from common disclosures like a lack of exercise or medication nonadherence to more infrequent behaviors such as not flossing or abusing pain medications.

In this dataset, a caregiver or family member was present during 11 of 83 disclosures. Disclosures in which a caregiver was present did not look significantly different than those in which a caregiver was not present. These were included in the sample analyzed for this chapter. However, disclosures in which a caregiver was directly *involved* in the disclosure sequence (e.g.,

in which the caregiver initiated disclosure or assessed the patient's behavior) did look significantly different from those disclosures in which a caregiver was not present. These were therefore excluded from the sample and not analyzed for this chapter. After analyzing all remaining instances of patient disclosure, I excluded from the collection disclosures regarding the following highly institutionalized healthcare behaviors – failing to bring pill bottles or blood pressure readings to the consultation, or failing to follow up on secondary care (e.g., podiatrist). These behaviors were addressed differently by both physicians and patients and were not oriented to as disclosures of medically problematic behavior.

Throughout this chapter, I refer to patient-initiated versus physician-initiated disclosures. A physician-initiated disclosure occurs when a physician makes a report of the patient's health behavior (e.g., exercise regimen) conditionally relevant (e.g., with a direct question). A patient-initiated disclosure occurs when a patient reports a problematic health behavior when a report was not conditionally relevant – though the report may be topically relevant or may contribute to a physician's project. In these data, 52% of disclosures were physician-initiated. Below, I provide a brief analysis of a physician-initiated disclosure and a patient-initiated disclosure to highlight the differences between these two types of reports.

Case I is an example of a physician-initiated disclosure. The patient in Case I has been living with diabetes for her entire adult life, and has just been informed that her A1C is seriously elevated.

Case I - Lowell (0603_1)

- 1 Doc: Are you stress eating? Are you- What are you doing. Cause you
- 2 were down better. Then it got a little worse, and now it's
- 3 even worse.
- 4 Pat: **You know what? Because: I stopped going to the gym.**

At line 1, the physician solicits an etiology for the patient's rising blood sugar levels, specifically an account for the blood sugar based on a health behavior ("What are you doing"). This makes a

report of her home health behavior conditionally relevant. At line 4, the patient provides an answer which discloses that she stopped going to the gym. Her report is built as an answer to the physician's question and she orients to her behavior as having caused the spike in blood sugar with the conjunction "Because:".

Case II is a patient-initiated disclosure. The physician and patient are discussing the patient's recent positive changes to his diet. His blood pressure has been high for about one year, but it recently went down somewhat. They are discussing what brought it down and how to bring it down further.

Case II - Highland (0803B_1)

1 Doc: Oh goo:d. Great. I mean they say lifestyle changes are very
2 important for high blood pressure:, diabetes:,
3 Pat: **The thing that I haven't been able to do is my workout**
4 **routine is just disappeared essentially at this point.**

At lines 1-2, the physician does not solicit a report of the patient's behavior, but rather makes a positive assessment of the patient's dietary changes and emphasizes the importance of lifestyle changes for high blood pressure and related conditions. At line 3, the patient builds the report of his exercise regimen as contrastive to diet ("The thing that I haven't been able to do is..."). In this way, the disclosure indicates an area he could work on to improve his high blood pressure, contributing to the physician's project at lines 1-2 of promoting lifestyle change. However, as the report is not conditionally relevant, this illustrates a patient-initiated disclosure.

Disclosing a medical misdeed can be a delicate activity, and some patients show significant hesitancy to disclose even after direct physician solicitation. However, other patients readily initiate disclosure of medical misdeeds with humor and embellishment, despite clear indications that they recognize their behavior as medically problematic. In this chapter, I present evidence that patients and physicians *approach disclosure differently* in the Highland and Hinsdale primary centers in high-income communities versus the Lowell and Lowry primary care centers in low-

income communities. See Chapter 1 for a more detailed description of these four communities. Table 1 provides a summary of the demographic characteristics of the local area surrounding each of the four healthcare centers discussed in this chapter.

Table 1.

	Consultations Filmed	Median Household Income	% Below Fed. Poverty Line	% Non-Hispanic White
Lowell	60	\$18,000	45%	7%
Lowry	15	\$28,000	35%	2%
Highland	45	\$118,000	1%	58%
Hinsdale	60	\$156,000	1%	83%

<http://www.city-data.com/>

Although I examine variation in physician orientations towards patients' health behaviors across different patient populations, my claims do not imply enactment of implicit bias (Teachman & Brownell 2001; Green et al 2007; Greenwald et al 1998). Namely, I do not examine the differences in how *the same physician* orients to patients of different backgrounds. Instead, I examine regularities in physician-patient communication across two very different *healthcare contexts* – primary care centers that service predominantly low-income communities of color and primary care centers that service predominantly high-income white communities. The analytic aim is to evaluate what provision of care looks like in these two healthcare contexts and use this to re-conceptualize discussions of patients' active self-presentation versus passive habitual behaviors in the clinical setting.

3.4 Analysis

In this chapter, I show that there are systematic differences in physician and patient approaches to disclosing a medically problematic health behavior across healthcare contexts. I begin by analyzing physicians' solicitations of information regarding the patient's lifestyle. I show that through the formulation of these questions (polarity and presupposition) and the projects they

contribute to (pursuing disclosure versus history taking), the physician communicates a positive or negative orientation towards the patient's lifestyle, before even hearing about the patient's health behaviors. These orientations shape the environment in which patients will disclose medically problematic behaviors. I compare question formulation and project across consultations in Highland and Hinsdale versus Lowell and Lowry.

I then analyze patients' initial disclosure turns. I examine the formulation of the disclosure (downplayed, unmarked or upgraded) and the contexts in which patients disclose (project and conditional relevance). I explore trends in patient presentation of medically problematic behavior across these four communities. I show that certain patients systematically emphasize the negative aspects of medically problematic behavior, present their behavior as unreasonable and use these disclosures to pursue physician intervention. Meanwhile, other patients systematically downplay negative aspects of their behavior, contributing to a more positive self-presentation. I discuss the theoretical implications of these findings in reference to Shim's (2010) cultural health capital framework.

3.4.1 Soliciting Reports of Health Behavior

Physicians communicate presuppositions, attributions and expectations about patients' lifestyle even before receiving a report of health behaviors. Key to this analysis is that they do this when *soliciting reports* of home health behavior. Physicians may produce questions that presuppose medically problematic health behavior, and they may build polar questions to anticipate a disclosure of problematic behavior. When soliciting these reports, they may pursue projects that link a medically problematic behavior to a personal circumstance or to a health outcome, for example indicating the patient's behavior contributed to a diagnosed condition. I begin this section of analysis by exploring the ways in which physicians can display a negative

orientation towards a patient's health behaviors *before being told what those behaviors are*. I ask whether physicians display more negative orientations towards patients' lifestyle in Lowell and Lowry.

3.4.1.1 Question Formulation

As discussed above, one way in which physicians display an orientation towards a patient's lifestyle is through question polarity. Case 1 provides an example of an optimized physician question about the patient's exercise behavior. The patient and physician have not discussed exercise in this consultation, but the patient was diagnosed with pre-diabetes earlier in the visit.

Case 1 – Highland

7 Doc: Do you exercise:,

The question is polarized to anticipate a yes-type answer (Sacks 1987; Heritage 2010) reporting she participates in the medically sanctioned behavior – that she does in fact exercise. Here, the physician does *not* display a negative orientation towards the patient regarding her health behaviors. Instead, she follows the principle of optimization (Boyd & Heritage 2006).

In contrast, the physician in Case 2 does not produce an optimized polar question. Like Case 1, the patient and physician have not discussed diet in the consultation, but the patient was diagnosed with pre-diabetes at the start of the visit.

Case 2 – Lowell

9 Doc: And then when it comes to: eating. What do you think is
10 the problem. Do you thi:nk .hh

The physician's question presupposes that the patient's diet is medically problematic (Heritage 2003) and is simply requesting an explanation about what the problem is. In this sense, she is not simply soliciting a report of the patient's behavior – she is soliciting *disclosure*. The physician displays a negative orientation towards the patient's lifestyle by presupposing problematic dietary behavior despite no earlier talk of diet. Like in Case 1, the patient was diagnosed with pre-diabetes

during this consultation, which *may indicate* the patient is not following a medically advisable diet or exercise regimen. Regardless, the physician in Case 1 builds her question to anticipate a medically sanctioned behavior, while the physician in Case 2 her question to presuppose medically problematic behavior.

Alongside optimization and presupposition, physicians can use other resources to emphasize or mitigate a negative orientation towards the patient's lifestyle. For example, physicians may qualify or mitigate their questions about lifestyle, or cite evidence that accounts for a question formulation anticipating medically problematic behavior. We see all of these resources in Case 3.

In Case 3, the patient has made an appointment to address a shoulder injury.

Case 3 - Lowry (0311 1A)

```

1 Doc: >I guess I< haven't seen you in two years.
2      (2.0)
3 Doc: Ri:ght? ((gaze to patient))
4 Pat: Been two years,
5 Doc: ((gaze to chart)) .hhhh khk khk ((coughs)) According
6      to this:: it was: ah September two thousand thirteen:: .hhh
7      (2.0)
8 Doc: And you're: (0.2) on:: (2.0) This ri:ght ankle, your-
9      Hypertension::, (1.8) So:: you:'ve bee:n (.) out of your
10     ((gaze to pat)) blood pressure medicines ((gaze to chart))
11     for that (0.3) long,
12     (0.8)
13 Pat: No. ((head shake))
14     (3.0)
15 Doc: ((head shake)) | (2.0)
16 Doc: I didn:'t (0.5) see any refills,=S:o you're g- how're you
17     getting ((gaze to patient)) refills.
18 Pat: My wife just ca:lls CVS and they re fill 'em. .hhh
19     (0.4)
20 Doc: ((writes in chart)) Ohkay. ((nod))
21 Pat: .hhhhh hhh ((loud sigh)) / (1.5)
22 Doc: Have you been takin' em recently:, or you been ((gaze to
23     patient)) missin'. (0.3) m[issin' some of em.
24 Pat: [I've been missing em.
25 Doc: ((writes in chart)) Okay.
26 Pat: .hhhh off and on,
```

As the consultation opens, the physician and patient exchange greetings and the physician looks at the patient's chart (transcript not shown). The physician then does a noticing while looking at the chart, observing that he hasn't seen the patient in two years (lines 1-2) and pursuing confirmation with a tag question (line 4). He then performs reading the chart out loud, marking the evidence on which he bases his subsequent request for confirmation. His request for confirmation (lines 9-11) is polarized towards a yes-type answer disclosing nonadherence (Sacks 1987). However, the patient denies this (line 13).

The physician then presents further justification for his understanding that the patient is not taking his medication, stating that he "didn't see any refills" (line 15) and asking the patient to reconcile how he is getting refills such that it does not show up in the medical file (lines 15-16). The patient answers the physician's question at line 17, claiming that CVS has nonetheless continued filling his prescription. After some hesitation, the physician accepts the patient's answer in third position at line 19. The physician pursues a report of medication (non)adherence one last time, asking a qualified question: whether "recently:" he has been taking or missing his medications (line 23). This time, the question is designed as an alternative with two options – taking or missing. Finally, with a report of recent (non)adherence conditionally relevant, the patient discloses that he has been missing his medications (line 23).

As outlined in Cases 1-3, physicians embed an orientation towards the patient's lifestyle in the formulation of health-behavior questions. Regularities in physician formulations of these questions reveal a more negative orientation towards the health behaviors of patients in Lowell and Lowry. Physicians were more likely to produce questions formulated to anticipate *problematic behavior* in these communities. Across physician questions that preceded disclosure, physicians in Lowell and Lowry were 2.9 times more likely than physicians in Highland and Hinsdale to

presuppose *problematic behavior* in the questions that prompted disclosure. Meanwhile, physicians in Highland and Hinsdale were 88% more likely than physicians in Lowell and Lowry to build questions polarized to anticipate a report of *non-problematic behavior*. At the same time, the *rate of disclosure* of medically problematic behavior was the same in the low- and high-income neighborhoods (50.7 disclosures per 100 consultations in Lowell and Lowry versus 51.1 disclosures per 100 consultations Highland and Hinsdale), so patients in Lowell and Lowry were no more likely to *disclose problematic behavior* compared to patients in Highland and Hinsdale.

3.4.1.2 The Physician's Project

Beyond question formulation, other aspects of question design display an orientation towards the patient's lifestyle. In this section of analysis, I discuss the relevance of their "projects" by which I mean the more general activity of which the question is part (Levinson 2013). Physicians' solicitations of health behaviors are only *sometimes* produced as straight history-taking questions. However, the majority of these questions pursue projects that may be linked to establishing etiology, diagnosis or treatment, and thereby contain additional embedded attributions regarding patient behavior. By soliciting a patient's health behavior within a given project, a physician can display a negative orientation towards that patient's health behaviors. To clarify what I mean by this, I provide a brief discussion of Case 3.

In Case 3, the physician initiates the project of checking whether the patient is taking his medications as prescribed at lines 9-11, after indicating that there is evidence of nonadherence in the chart (lines 1/8-9). The physician is recognizably pursuing a project of confirming that the patient has not been taking his medications. In this way, he displays a negative orientation towards the patient's lifestyle, thereby shaping the local context in which the patient will report his health behavior. A full second and a half of silence follow, as the physician writes in his chart. At this

time, a disclosure of medication nonadherence is not conditionally relevant, but if one were made, it would contribute to the physician's project of confirming whether the patient is taking his medications.

In Lowell and Lowry, physicians' projects were often aimed at *uncovering patients' problematic behavior* (e.g., uncovering health behaviors that may have contributed to a patient's health concern [Case 2] or uncovering health behaviors following evidence from the chart or bloodwork [Case 3]). Case 4 provides an example in which the physician goes further than uncovering the patient's problematic behavior by requesting information about a behavior *she was previously aware of* in the context of establishing what may have contributed to the patient's health concern. This works to emphasize the negative orientation towards the patient's lifestyle.

In Case 4, the patient is describing her deep cough, which has continued for months. The patient has been smoking for over 30 years, which is something the physician and patient have discussed in past consultations.

Case 4 – Lowell (0613_1)

1 Pat: But y- At work I'm noticing it's worse. ((referring to
2 cough)) They're doing that construction, and as soon as they
3 moved things,
4 Doc: Oh yeah the big metro- or whatever building that is.
5 Pat: Yeah and it's really [dusty: and it's
6 Doc: (((quiet)) Are you still smoking,
7 Pat: Of course.

The patient informs the doctor that she noticed (see Halkowski 2006) that her cough worsened when they began doing construction near her workplace (lines 1-3). In doing so, she presents air quality as a potential reason for the worsening of her symptoms. The physician displays recognition of the construction site (line 4) and the patient continues to describe it as "really dusty:" further promoting air quality as a potential cause for the worsening cough. In this context, the physician asks the patient if she is still smoking at line 6. Given the topic of air quality (lines 1-5),

the polarization of the question to expect a yes-type answer (line 6), and the physician's prior knowledge of the patients' smoking, the question can be understood primarily as indicating that smoking is another potential contributing factor to the cough. The patient responds with "Of course" thereby contesting the presupposition of askability (Stivers 2011) for a question which the physician already knows the answer to. By asking the question in this position, the physician doesn't just make a request for information, but she indicates that the patient may be *contributing to her own symptoms* by continuing to smoke. In these ways, the physician's question displays a negative orientation towards a patient's lifestyle.

In contrast, in Highland and Hinsdale physicians do not tend to display a negative orientation towards patients' lifestyles in this way. In these instances, the questions that prompt disclosure often contribute to routine history-taking or to physician projects that are built on the presupposition of medically advisable health behaviors. In these cases, patients correct the presupposition of non-problematic behavior built into the physician's project. An example of this is provided in Case 5.

In Case 5, the patient has recently been prescribed a cream from a dermatologist. At line 1, her primary care provider asks how the new cream has been working.

Case 5 – Hinsdale (10.28.16.A1)

1 Doc: **Has the creams:: been working?=Did you notice a difference,**
2 **I'm just curious.**
3 Pat: You know? I didn't notice a difference. Everybody-
4 Doc: Mhm,
5 Pat: Other people did, But I don't-
6 (1.0)
7 Pat: I prob'ly use it °once a week.°
8 Doc: O::h really,
9 Pat: Yeah. Yeah. I'm not very good at it.
10 (0.5)
11 Pat: Remember I don't take any medication I'm [like ((laughs))
12 Doc: [Yeah I remember.
13 Pat: I'm not good at complying. ((laughs loudly))
14 Doc: ((laughs)) We a:ll aren't. It's not you it's our kind.
15 Alright::? [((laugh)) ()

16 Pat: [Except for a while people were noticing a
17 difference. Shee was noticing a difference,

By asking these two questions (lines 1-2) the physician initiates the activity of establishing whether the dermatologist's prescription has been effective. The patient's answer first asserts that she didn't notice a difference, indicating that the cream was not effective. However, she cuts off "everybody" in her second TCU, replacing it with "Other people" in contrast to the prosodically marked "I" from her first TCU. Thus, in her second TCU she builds the contrast, consistent with the physician's presupposition of using the cream. She then begins to provide another contrast set up with the "but" preface (line 5) (Mazeland & Huiskes 2001) but again cuts off her TCU (line 5).

Though the patient has provided an answer response to the physician's question by line 6, the patient reveals in line 7 that in fact the presupposition that the patient has been using the topical medication as prescribed (lines 1-2) is incorrect. By correcting this presupposition, the patient offers a possible account for her position that the treatment has made little difference. The patient then accounts for her nonadherence (lines 9/11/13) and the patient and physician laugh (lines 11/13-15). In overlap with the physician normalizing the patient's nonadherence (lines 14-15), the patient returns to her description of *who noticed a difference* once she started using the topical medication (lines 16-17). By pursuing a project that presupposed patient adherence, the physician displays a positive orientation towards the patient's lifestyle. This contrasts with Case 2, Case 3 and Case 4 above.

In Highland and Hinsdale, the most common physician-initiated project prompting disclosure was *routine history-taking*, while in Lowell and Lowry the most common physician-initiated project prompting disclosure was *promoting behavior-change*. In this way, physicians in Lowell and Lowry display a negative orientation to patients' lifestyle. These trends not only reveal fundamental disparities in how discussions of medically problematic health behaviors are initiated

in low- versus high-income communities, but they also document the contexts in which patients then go on to *present* their disclosures, and shape the ways in which patients report their health behaviors to their physicians. Next, I turn to an analysis of variation in how patients disclose medically problematic behaviors.

3.4.2 Patient Reports of Medically Problematic Behavior

Patients often do additional interactional work to present themselves as reasonable when disclosing medically problematic behavior. Patients may qualify or mitigate their disclosed behavior. They may hold off disclosing until it is made conditionally relevant, or they may disclose to contribute to a physician's agenda. However, the counterintuitive finding presented in this section involves the large percentage of patients who do additional work to present themselves as having participated in *unreasonable behavior*. I begin this section of analysis by analyzing patient framing of their behavior, then examine the contexts in which patients disclose problematic health behaviors. I examine the contexts in which patients pursue a more positive or negative self-presentation when disclosing medically problematic behaviors, and I discuss the implications of these findings.

3.4.2.1 Framing of Health Behaviors

This section of analysis takes a closer look at regularities in how patients frame or characterize medically problematic behavior across high-income white communities and low-income communities of color. I conceptualize disclosures as on a continuum, with downplayed and upgraded disclosures on either end and unmarked disclosures in the middle. Patients downplay problematic behavior through mitigation, qualification and positive framing. Though we might expect patients to almost always downplay their reports of medically problematic behavior, only 38% (27 of 72) of disclosures were downplayed.

Patients downplay their behavior by qualifying or mitigating the extent of the behavior. Though all patients do display an orientation to their disclosed behavior as problematic, these disclosures are characterized by the use of *additional interactional resources* to mitigate the severity of the disclosure. In this way, patients perform additional interactional work to present themselves as having participated in medically problematic, but relatively reasonable, behavior. To illustrate, an example of is provided below.

In Case 6, the physician has initiated a discussion of an older patient's regular use of nitroglycerine for chest pain. This is a first-time consultation for this physician and patient.

Case 6 – Lowell (0617_3)

1 Pat: But (.) when I have the have chest pain if it get too serious
2 I call the (.) paramedics.
3 Doc: Okay. (.) Have you ever smoked in the past?
4 Pat: .tlk I sti:ll do a little [smoking from time to time].
5 Doc: [You still smo:ke?,
6 Pat: Yeh.
7 Doc: You know that's the worst thing for your heart.

After a discussion about how much nitroglycerine the patient uses (transcript not shown), the patient reports that when his heart symptoms get too serious, he calls the paramedics (lines 1-2). The physician responds with an “Okay” and asks whether the patient used to smoke. With the negative polarity item “ever”, the question is optimized for a no-type answer (Boyd & Heritage 2006). Instead, the patient discloses that he currently smokes (line 4) but minimizes the amount (“a little”) and frequency (“from time to time”) of his smoking. The physician requests confirmation that he is currently smoking (line 5), adding stress to the negative polarity marker “still” and the patient confirms (line 6). The physician responds by asserting that smoking affects the patient's heart, emphasizing the disclosure by describing smoking as “the worst thing” for the patient's heart (line 7).

Returning to the cases analyzed earlier in the chapter, we can observe that Case 3 featured downgraded disclosures. In Case 3, the patient downgrades his disclosure by mitigating the frequency of his behavior.

Case 3 - Lowry

22 Doc: Have you been takin' em recently:, or you been ((gaze to
23 patient)) missin'. (0.3) m[issin' some of em.
24 Pat: [I've been missing em.
25 Doc: ((writes in chart)) Okay.
26 Pat: .hhhh off and on,

Another interactional resource that patients use to downplay disclosure is to *re-frame* medically problematic behavior as having positive dimensions, or using the disclosure to highlight *other* positive behaviors, thereby doing clear self-presentation work. The patient in Case 7 scheduled the appointment following a hospitalization for heart palpitations. The physician has been asking questions about what may have caused the patient's heart palpitations, including health behavior like drinking alcohol and family medical history. In this context, the physician's question at lines 4-5 is hearable as further contributing to the physician's agenda of establishing etiology for the heart palpitations.

Case 7 - Lowry (0304 2)

1 Pat: I know people that have it but not- nobody in my family.
2 Doc: Now.
3 (1.0)
4 Doc: You've been on blood pressure medicine.=Did you forget to take
5 it someti:mes?
6 (2.0)
7 Pat: **U::m (0.5) Well sometime here and ^there but.=**
8 Doc: =Well I mean nobody's perfect [but I mean: like Yea:h I'd
9 Pat: [Yeah.
10 Doc: forget like ya know wouldn't ta- take it about maybe twice a
11 week or [something like that.
12 Pat: [O:h no no no no no. I'm I'm usually on mine every
13 day though. .h If I miss- If I like (.) don't take it, .hhh
14 it's probly on the weeke:nd, like when I know I'm 'bout to
15 drink or something like that, have a (.) [drink,
16 Doc: [((cough))
17 Pat: **Then I'll try to not like mix those two together. But usually**
18 **every morning though. I take my medicine. Sometimes at night**
19 **also.**

20 Doc: Okay. Now. This is the first time I've been able to go over
21 this lab work with you.

The physician's question at lines 4-5 is not optimized, but rather polarized to expect a yes-type answer disclosing medication nonadherence. After two full seconds of silence and further hesitation the patient produces a downplayed disclosure, mitigating the frequency of the behavior twice over (line 7).

The physician pursues a more specific report of the patient's health behavior, clarifying that he means missing medication "about maybe twice a week" (lines 8/10-11). The patient responds in overlap, producing a change of state token and repeating "no no no no no no" (line 12) treating the physician's course of action as off-base (Stivers 2004). This time, he re-frames his level of adherence as "usually on mine every day". This projects adherence as the *norm*, to which there are some exceptions (lines 12-13). The patients then goes on to describe these exceptions, explaining that if he doesn't take it, it's a conscious decision to avoid mixing the medication with alcohol (line 13-15/17). This contrasts with the physician's indication that the patient may be *forgetting* to take his medications (line 4, line 10). The patient even goes so far as to assert that he tries not to "mix those two together" (line 17). The patient then reiterates that he takes it "usually every morning" (lines 17-18), then clarifies that he sometimes takes it at night (lines 18-19). Notably, the patient could have framed this same report of his health behavior as 'I skip my medications when I drink heavily on the weekends' or 'I don't take the medication at the same time every day.' Instead, he re-frames a report of medically problematic behavior (line 7) as positive behavior (lines 12-15/17-19), thereby displaying a strong sensitivity to how his description of his health behavior may impact his status as a 'good patient' who follows medical advice.

Stepping back, patients in Lowell and Lowry were 70% more likely to downplay their disclosures than patients in Highland and Hinsdale. This trend starts to reveal a patient orientation

towards positive self-presentation in Lowell and Lowry – patients in these communities are systematically doing more work to present their behaviors in more qualified, mitigated, and otherwise downplayed forms. To compare, patients from high- and low-income communities produced unmarked disclosures at nearly the same rate (32% versus 27% respectively). Unmarked disclosures are neither upgraded or downplayed – they are simply factually presented. Case 8 provides an example of an unmarked disclosure.

In Case 8, the patient has come to the consultation to address her significant weight gain. As the transcript opens, the patient has just moved to the examination table and the physician is asking questions during the physical examination.

Case 8 – Highland

- 1 Doc: Are you walking:?
- 2 Pat: Yeah.
- 3 Doc: Every da:y,
- 4 Pat: **Not every da:y.**

The patient's disclosure at line 4 is a negative repetitional answer. There are no additional components that work to either emphasize or de-emphasize the extent to which she *does not walk every day*.

Returning to Case 4, we see another example of unmarked disclosure.

Case 4 – Lowell

- 6 Doc: ((quiet)) Are you still smoking,
- 7 Pat: **Of course.**

The disclosure at line 7 contests the presupposition of askability (Stivers 2011) given that the physician has known about her smoking habit for many years. Although it is not a straight interjection or repetitional answer, the disclosure still does not contain any components that emphasize or de-emphasize the amount she is smoking or the impact of the smoking on her health.

While we see variation in the extent to which patients downgrade their disclosures in these two healthcare contexts, more striking is the variation in the rate at which patients *upgrade* their

characterizations of medically problematic behavior. Patients upgrade their disclosures by using descriptive negative language, making explicit negative assessments and highlighting the medically problematic aspects of their behavior. Upgrading a disclosure of a medical misdeed is counter-intuitive, yet common. On average across the dataset, patients upgraded their behavior in 33% (24 of 72) of disclosures.

It may sound improbable that patients recurrently display ownership of medically problematic behavior. However, a return to the disclosures presented in the previous sections confirms that this is in fact a routine practice. For example, we can review Case II from the Data Section.

Case II – Highland

1 Doc: Oh goo:d. Great. I mean they say lifestyle changes are very
2 important for high blood pressure:, diabetes:,
3 Pat: **The thing that I haven't been able to do is my workout**
4 **routine is just disappeared essentially at this point.**

Returning to the disclosure at lines 3-4, we can see that the patient doesn't simply report that he is not following a workout routine. Instead, using "my workout routine" as a pivot (Walker 2007) he discloses the same behavior twice. The first disclosure is formulated as a report of a personal failing ("the thing that I haven't been able to do is my workout routine") and the second disclosure is formulated as a description of the trajectory of his exercise routine, using an extreme formulation to report that he no longer has a workout routine ("my workout routine is just *disappeared essentially*"). This actually exacerbates the severity of the behavior being disclosed – doing the opposite work of mitigation. Case II provides an example of a patient highlighting the (in)frequency of the reported behavior. But these disclosures are upgraded in other ways as well – specifically by highlighting on the impact of the behavior on health.

For an example of this, I present Case 9, in which we see a granular description of the negative impact the behavior has on the body.

Case 9 – Highland

1 Pat: I'll relax go to bed and it stops and it's not there in the
2 morning. ((referring to heart palpitations)) I don't know
3 what causes it. **But I mean I'm smoking. Well you know I'm-**
4 **You know you're giving yourself shots of nicotine,**
5 Doc: You're still smoking:?
6 Pat: Yea:h.

The patient begins with a straightforward report that she is smoking (line 30). However, she doesn't stop there. She then depicts smoking as “giving yourself shots of nicotine” likening the behavior to injecting a poisonous substance into her body (line 4). In the context of discussing heart palpitations, this is also hearable as an upgraded bid for this being a potential cause of the heart palpitations. Though the behavior itself is not upgraded (e.g., smoking *a lot* or smoking *often*), it is characterized in a way that is particularly harsh, exacerbating the negative health effects.

As we begin to see with Case 9, upgraded disclosures are not limited to minor health behaviors which are considered relatively socially acceptable, or even those that are considered common. Case 10 provides an example of an upgraded disclosure of drug use. The patient in Case 10 presented with halitosis (severely bad breath) and has been proposing possible sources of the halitosis. In this context, he initiates a disclosure of smoking. There is initially some confusion about whether he is referring to cigarettes or marijuana (transcript not shown). At line 2, the physician requests confirmation that the patient is referring to smoking marijuana only.

Case 10 – Hinsdale

1 Pat: [Never smoked cigarettes no.
2 Doc: Just marijuana?
3 Pat: **Just marijuana. Yeah. And it's (your) bo:ngs and joints and**
4 **blunts and that kind [of thing.**
5 Doc: [Everything,
6 Pat: **Yeah. Um: and did that, And really dove in and was like- if I**
7 **gave you the numbers a lot of people doing now days it would**
8 **blow some doctors minds? But um it was like .hh I dunno like**
9 **six blunts a day, seven blunts a day, stuff like that. Probly**
10 **mo:re? Rounding down. [But.**
11 Doc: [Okay.

The patient begins with a straightforward report that he is smoking marijuana, but he doesn't stop there. He answers the physician's question with a repetition followed by a confirmation (line 3). Given that the physician's request for confirmation treated marijuana as relatively minimal with "just", when the patient goes on to further explain his smoking habits, he is not underscoring its minimality. Rather, he upgrades the behavior by underscoring both the ways he is consuming marijuana (bongs, joints and blunts) and the amount. Moreover, he doesn't simply report that he smoked six to seven blunts a day – he reports that he "really dove in" and asserts that these numbers would "blow some doctors minds" (lines 6-10). When the physician doesn't produce a verbal or visible response at line 9, the patient upgrades his estimate, asserting that the number is "Proibly mo:re?" and that he was rounding down.

These findings indicate that certain patients display a willingness not only to propose that their behavior may be causing a health issue, but to also lean in to those reports of problematic behavior and emphasize their acceptance of aspects of their behavior that they treat as medically problematic. Moreover, patients also show a willingness to upgrade even when physicians work to downplay their behaviors for them. Case 11 provides an example of this.

The patient in Case 11 has made an appointment to address a bad cough. The physician reported that the patient's blood pressure is high at the opening of the consultation and prescribed medication to treat the high blood pressure. Case 11 opens just after the treatment recommendation. The physician is referencing the blood pressure medication at line 1.

Case 11 – Highland

```
1 Doc: It's pretty well tolerated without food.
2 Pat: ^Okay.
3 Doc: Let me have you sit up here.
4 Pat: Great.
5 Doc: Let's listen to this.
6      (1.0) | ((patient sits on exam table))
7 Doc: Do you exercise:,
```

8 Pat: ((head shake, cough)) No.
 9 Doc: Not with this. Especially. ((referring to cough))
 10 Pat: **No. Not at all. But I guess I'm going to.**
 11 (7.0) | ((physician listens to patient's lungs))

At line 3 the physician directs the patient to sit on the exam table, initiating a transition to the physical exam for the cough. After watching the patient move to the exam table, the physician asks if the patient exercises (line 7). The patient provides a straightforward disclosure – an unexpanded interjection response to the physician's polar question (line 8) (Stivers & Enfield 2010). However, he also coughs loudly during the turn. It is not clear whether the cough is unintentional or an intentional communicative act that implicitly resists the physician's line of action or builds towards an account for his lack of exercise. Regardless, the physician orients to the cough as interactionally relevant and provides a qualification or account for the patient's lack of exercise – he is not exercising “with this” cough (line 9). In this way, the physician downplays the patient's disclosed behavior. However, instead of nodding along, the patient resists the physician's qualification/minimization (line 10). He informs the physician that he doesn't exercise “at all” thereby upgrading his report of the behavior. He then indicates that he will change his behavior. The physician does not respond and begins to listen to the patient's lungs with her stethoscope (line 11).

Patients systematically upgrade their characterizations of medically problematic health behaviors in certain healthcare contexts. Patients in Highland and Hinsdale were 2.5 times more likely than those in Lowell and Lowry to upgrade their disclosures. While disclosures in Highland and Hinsdale were *upgraded* close to half the time (44%), disclosures in Lowry and Lowell were *downplayed* exactly half the time (50%). We can summarize the differences in patient framing of the behavior in Table 1.

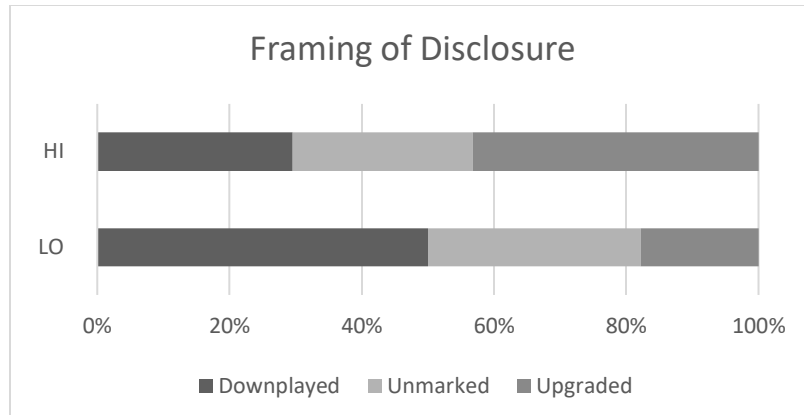


Table 1. Ratio of Downplayed, Unmarked and Upgraded Disclosures in Highland & Hinsdale (HI) versus Lowry and Lowell (LO)

We not only find that patients in Lowell and Lowry do relatively more interactional work to present themselves as reasonable despite disclosure, but that patients in Highland and Hinsdale do relatively more interactional work to present their behaviors as *unreasonable* from a medical perspective. Returning to Case 5, for example, we can recall the patient’s account for her medication nonadherence: “I’m not good at complying. ((laughs loudly))” (lines 13). However, it quickly becomes clear that such counter-intuitive findings do not provide a full picture of the ways in which high- versus low-income patients orient to disclosure and self-presentation. I will show in the next section that presenting one’s behavior as *unreasonable* is in fact a *tool* that high-income patients rely on to pursuing their *own* projects such as lobbying for a particular treatment. For evidence, we turn to a discussion of patient projects and the contexts of disclosure.

3.4.2.2 Contexts of Disclosure

In Section 3.4.1.2, I discuss how physicians often solicit disclosures in pursuit of a commitment to behavior-change or to propose an explanation of the patient’s illness. Similarly, patients often initiate disclosure to negotiate treatment or propose an explanation of their illness (Bergen & Stivers 2013). By embedding the disclosure within a particular project, the patient displays an orientation towards self-presentation. Patients also display an orientation towards self-

presentation by volunteering problem behavior independently versus *only* once it has been made conditionally relevant by a physician's question. To illustrate these two points, I start by comparing two cases in which the patient discloses a problem with diet – one disclosure that is physician-initiated and contributes to a physician's bid for a commitment to behavior change, and one disclosure that is patient-initiated and contributes to patient's bid for treatment.

I return to an expanded extract of Case 2 from Lowell. The patient in Case 2 was diagnosed with pre-diabetes earlier in the consultation. At that time, the physician and patient had an extensive discussion about the patient's exercise habits. This extract occurs much later, towards the end of the consultation. This patient has a job that keeps her at an office in the late evenings.

Case 2 – Lowell

1 Doc: Are you taking any multivitamin?
2 Pat: No.
3 Doc: You should.=
4 Pat: =Okay.
5 (0.5)
6 Doc: Not just Ca:lcium. [Vitamin D as well.
7 Pat: [Just (). Okay.
8 ((doctor writing in chart | 5.0))
9 Doc: And then when it comes to: eating. What do you think is
10 the problem. Do you thi:nk .hh
11 Pat: **((quietly)) Late night eating.**
12 Doc: Late night eating. hhh
13 Pat: Yeah.
14 Doc: Yeah.
15 Pat: **I know that's my problem.=I get home la:te and then I .hh I'm**
16 **hungry and I eat.**
17 Doc: Is there any way you can: (0.3) fix tha:t,
19 Pat: I'm gonna work on that. I- I I I should. I'm gonna. Maybe
20 have a snack before I leave work and then not eat dinner or
21 something?

As the transcript opens, the physician is in the process of finalizing her treatment recommendations and proposed next steps. She recommends that the patient begin taking a multivitamin (lines 3/6), and the patient agrees (lines 4/7). In this context, the physician asks an open question about the patient's eating that presupposes that there is a "problem" with the patient's diet (lines 9/10). She specifically requests a report of what about her diet is medically

problematic. In response, the patient discloses that she has been eating late at night (line 11). At line 15, the patient explicitly characterizes the late night eating as “my problem.” By disclosing in this context, she presents herself as someone interested in contributing to the physician’s efforts to improve her health, despite having participated in “medically problematic” behaviors in the past. Notably, she did not voluntarily disclose this information earlier in the visit.

The physician then asks if the patient can “fix that,” advising behavior change (line 17). The patient responds with a commitment to behavior change and then proposes a plan to carry out that behavior change (lines 19-21). Ultimately, the patient contributes to the physician’s project of establishing better eating habits so as to improve her blood sugar, thereby doing positive self-presentation work as she discloses medically problematic behavior.

Though both patients in Case 2 and Case 12 are Latina women in their 40’s with relatively similar health histories and long-term established relationships with their female primary care providers, and though both patients reported similar medically problematic dietary behavior, these two discussions of diet were initiated in very different ways and contributed to very different healthcare projects.

The patient in Case 12 also has pre-diabetes but is in the Highland primary care center. This extract occurs at the opening of the consultation, just after the greetings. The patient’s wife, Kelsey, has recently had bariatric surgery and is now eating less. The patient and physician have known one another for many years, and they have discussed the possibility of bariatric surgery for this patient in the past.

Case 12 – Highland

1 Pat: I mean I've been thinking about um (.) the: the bariatric
2 [surgery.
3 Doc: [Ye^a:h.
4 Pat: Cause it's like- Yeah::. I've gotta protect myself.
5 Doc: ((laugh))
6 Pat: **I started a ne:w bad habit.**
7 Doc: Uh oh what (.) 's the new bad habit.
8 (1.5) ((patient mimes eating))
9 Pat: °**Eating Kelsey's leftovers.**°
10 Doc: Oh:::: no:[::::.
11 Pat: [°**It's bad.**°

At line 1, the patient initiates a topic shift and announces that she has been considering bariatric surgery. The physician comes in with a loud agreement in overlap (line 3), indicating that she is supportive of the idea, though not explicitly agreeing to the idea or transitioning to a substantive discussion of next steps. The patient begins the next turn with the conjunction “Cause”, but then initiates self-repair (Schegloff, Jefferson & Sacks 1977) before asserting that she needs to “protect” herself (line 4), providing an account for considering the surgery and upgrading her disclosure. The physician laughs, and the patient makes a pre-announcement (Terasaki 1976), telling the physician that she “started a ne:w bad habit” (line 6). This builds her forthcoming report of her behavior as a disclosure. In this position, the pre-announcement also frames the forthcoming disclosure as a reason she needs to “protect” herself, tying it to a bid for pursuing bariatric surgery. The physician gives a go-ahead (line 7) and the patient discloses that she has started eating her wife’s leftovers (line 9).

The patient’s negative assessment at line 11 further upgrades her bid for pursuing bariatric surgery. In this way, the patient’s disclosure is presented as a reason to consider this form of treatment. Unlike Case 2, the patient in Case 12 volunteers the disclosure without physician prompting, early in the consultation. The disclosure contributes to the *patient’s* project of making a bid for bariatric surgery – a project distinct from establishing behavior change. The fact that the

patient's disclosure is upgraded (lines 4/6/8) further contributes to the project of making a bid for bariatric surgery.

These cases help us to see how presenting one's behavior as unreasonable is in fact one way that high-income patients display a willingness to change their behavior but the behavior change is actually part of their own projects. Returning to the upgraded disclosures presented in the previous section, it becomes evident that patients are using upgraded disclosures to securing treatment (e.g., negotiating treatment as in Case 12) or medical advice (e.g., proposing etiology as in Case 9 below).

Case 9 provides another example of a patient's upgraded disclosure contributing to the project of proposing an etiology for her health condition. I return to an expanded extract of Case 9.

Case 9 – Highland

1 Doc: But (.) we can try that first,=And then if you can write
2 do:wn? when it happens:, and what you're [doing.
3 Pat: [It's It's really at
4 different ti:mes. Sometimes I'm .h you know (.) laying there
5 reading: or watching TV. I mean it'll just start,
...
10 Pat: relax and it stops and it's not there in the morning. I don't
11 know what causes it. [**But I mean I'm smoking and it's like**
12 Doc: [Yeah.
13 Pat: **well you know y- you're giving yourself shots of nicotine:**,
14 Doc: You're still smoking?
15 Pat: Yeah:.

A report of the patient's smoking behavior is not made conditionally relevant in the physician's prior turn (lines 1-2). However, the physician does make etiology relevant by asking the patient to write down what she is "doing" when the symptoms occur. The patient initiates a stepwise topic shift (Jefferson 1985) and describes experiencing heart palpitations while resting and watching television (lines 3-5, transcript not shown). While describing the contexts in which her symptoms arise, the patient asserts that she doesn't know "what causes it" (lines 10-11), but immediately

follows this with a counter and announcement that she is smoking (line 11). In these ways, she identifies smoking as a potential contributing factor to her heart palpitations. It is *the patient* that initiates stepwise topic shift to both describe when her symptoms occur, then to present a potential “cause” of the palpitations. In this sense, the patient’s turn is recognizable as patient-initiated and contributing to the patient’s project of establishing smoking as a cause for her heart palpitations. Upgrading the disclosure (as detailed in the previous analytic section) works to strengthen the patient’s bid for smoking as a potential contributing factor in her heart palpitations. The physician and patient then go on to discuss smoking cessation medication options.

Examining an expanded extract of Case 10, we see a similar pattern. Prior to line 1, the physician is looking at the patient’s chart, mumbling and typing in the computer.

Case 10 – Hinsdale

1 Pat: A:: huge thing that I was talking to the girl before too is.
2 .h I don’t know if it has anything to do with it?
3 (0.5)
4 Pat: But (.) all my research and stuff,
5 Doc: Mm: [hmm?
6 Pat: [Through Candida onli::ne,
7 Doc: Mm [hmm,
8 Pat: [They say if you smoke wee:d or smoke cigarettes, that (.)
9 it (.) like (.) doubles the: the-
...
31 Pat: [Never smoked cigarettes no.
32 Doc: Just marijuana?
33 Pat: **Just marijuana. Yeah. And it’s (your) bo:ngs and joints and**
34 **blunts and that kind [of thing.**
35 Doc: [Everything,
36 Pat: **Yeah. Um: and did that, And really dove in and was like- if**
37 **gave you the numbers a lot of people doing now days it would**
38 **blow some doctors minds? But um it was like .hh I dunno like**
39 **six blunts a day, seven blunts a day, stuff like that. Probly**
40 **mo:re? Rounding down. [But.**
41 Doc: [Okay.

At line 1, the patient produces a pre-announcement (Terasaki 2004). He then reports that his online research indicates that smoking marijuana and cigarettes can cause proliferation of a pathogenic yeast in the mouth, implying that this could be contributing to his primary health concern (lines

4/6/7-9/transcript not shown). In this context, the subsequent disclosure (line 33) is hearable as building a case for a candidate etiology. By upgrading his disclosure (lines 33-34/36-40), he strengthens the case for this candidate etiology. In this way, the upgrade does more than just emphasize the extent of his smoking; it also contributes to the patient's project of proposing smoking as a candidate etiology and thereby pursuing physician advice regarding the impact of smoking on his halitosis. The patient and physician then move on to discuss the patient's recent attempts to quit smoking.

Across these data, certain patients systematically display a high level of entitlement to *use* disclosures of medically problematic behavior to pursue projects such as negotiating treatment (Case 12) and establishing an etiology for their health problem (Case 9, Case 10) (see Bergen & Stivers 2013). Other patients do not display such an entitlement and their disclosures typically contribute to physician-side projects such as pursuing a commitment to behavior change (Case 2). Examining the contexts in which patients take these approaches, it is apparent that there are divisions across class lines. Patients attending the clinics in the high-income neighborhoods of Highland and Hinsdale *initiate disclosure* 70% more frequently than patients in Lowell and Lowry. Patients that did initiate disclosure in Lowell and Lowry typically contributed to *physician projects* when they did so, for example assisting the *physician's* search for a cause of illness. Patients initiating disclosure in Highland and Hinsdale contributed to a wide variety of *patient projects*, for example promoting their candidate diagnosis or negotiating treatment.

3.5 Discussion

Medical sociologists are increasingly turning to cultural health capital (Shim 2010) as a theoretical framework to explain patient behavior in a stratified healthcare system. The foundation of cultural health capital lies in Bourdieu's (1986, 1990) conceptualizations of habitus, field and

cultural capital, which played a significant role in shaping the way Sociologists have approached discussions of social status, authority and privilege. However, an examination of how patients *frame* their reports of medically problematic behavior doesn't, on the surface, align with the theoretical framing of cultural health capital. While patients in low-income communities of color do additional interactional work to present their disclosed behavior as reasonable, patients in high-income white communities perform additional interactional work to present their behavior as *unreasonable*.

Patients in Highland and Hinsdale (high-income white communities) routinely upgrade their descriptions of their behavior, thereby presenting themselves in a way that *does not* reflect the characteristics that tend to be rewarded in clinical settings (see Shim 2010) such as a belief in the value of self-discipline (“I’m not good at complying ((laughs loudly))” Case 5), a proactive stance towards health (“my workout routine is just essentially disappeared at this point” Case II), and a sensitivity to interpersonal dynamics (“if I gave you the numbers a lot of people are doing now days it would blow some doctors minds?” Case 10). Meanwhile, patients in Lowell and Lowry (low-income communities of color) routinely downplay their disclosures, thereby presenting themselves as having characteristics that *do* tend to be rewarded in clinical settings: a sensitivity to interpersonal dynamics (“I sti:ll do a little smoking from time to time.” Case 6), a proactive stance towards health and belief in the value of self-discipline (“Then I’ll try to not like mix those two together. But usually every morning though. I take my medicine.” Case 7).

Moreover, these findings build on research showing that disadvantaged patients consider positive self-presentation relatively more important to receiving quality care, when compared to their more advantaged counterparts (Malat et al 2006). Regardless of the extent to which this work is strategic or habitual, I show that all patients leverage these positive self-presentation strategies

in the clinical encounter, but that disadvantaged patients do so relatively more frequently (see Table 1). Thus, an analysis of patient framing alone might suggest that the topic of *health behavior* is an exception to the theoretical framework of cultural health capital.

However, when *action and project* are analyzed alongside framing, it becomes evident that patients in Highland and Hinsdale do not simply have a tendency to use upgraded framings; rather they routinely rely on upgraded framings to support *projects* that do reflect the characteristics that tend to be rewarded in clinical settings. Examining variation in turn design alone does not provide full theoretical leverage here – to do that, I build a broader analysis of how turn design is fitted to action and project. This, of course, is not a new approach in the field of conversation analysis. Although “talk has been the central *focus* of Conversation Analysis, its primary *objective* is not language... but rather action” (Mondada 2018, italics added for emphasis).

Patients’ upgraded disclosures overwhelmingly contribute to projects aimed at pursuing quality care. For example, in Case II the patient discloses “my workout routine is just essentially disappeared at this point”. Where the turn design in itself does not indicate a proactive stance towards health, the project that the turn contributes to *does* indicate a proactive stance towards health. The patient uses the disclosure to initiate a discussion of exercise and shortly thereafter asks whether his lack of exercise could be “contributing to” his high blood pressure. By disclosing this lack of exercise, he builds a case for a candidate etiology. By upgrading his disclosure, he strengthens that case. He then explicitly seeks a medical opinion on this candidate etiology, and physician and patient discuss ways the patient could build an exercise regimen into his busy schedule. Ultimately, the patient is hearable as pursuing lifestyle advice from the physician i.e., pursuing quality care.

The patients in Highland and Hinsdale display a willingness to emphasize medically problematic aspects of their behavior *in pursuit of* treatment, advice, and other aspects of quality care. This, in itself, is a way in which patients in these communities leverage cultural health capital. Thus, instead of examining whether or not certain patient populations activate cultural health capital (CHC), I uncover two competing forms of CHC which are differentially leveraged across these high- and low-income communities. In Lowry and Lowell patients rely primarily on *positive self-presentation*, downplaying their reported health behaviors. In Highland and Hinsdale patients rely primarily on *negative self-presentation*, using upgraded reports of their health behaviors to promote physician intervention. Patients in all four communities produced unmarked disclosures at approximately the same rate.

These findings contribute a unique perspective to a broader discussion of the ways in which cultural health capital is exchanged on the ground. By taking a fully inductive approach and adding layers of inquiry, this research goes beyond an analysis of patient possession of CHC and uncovers a relationship between competing forms of CHC. Conversation analysis provides a set of tools that can be used to systematically identify and analyze subtle variations formulation, action and project. Ultimately, CHC is exchanged through formulation, action and project, as evidenced by these findings. In this sense, the methodology is well suited for the study of the micro-interactional processes of social stratification in institutional settings, drawing on the theoretical framework of CHC to organize discussions of social status and privilege.

Most sociological research that uses the framework of CHC takes is based in ethnography. Taking a conversation analytic approach allows us to reconceptualize CHC in a slightly different way. While the CHC framework emphasize individuals' ability to use and exchange both habitual and strategic interactional resources, conversation analysis emphasizes the ways in which prior

talk and institutional environment shape individuals' use of interactional resources. Neither approach will predict interaction with perfect certainty, so reconciling both frameworks proves advantageous when studying variation in patient interaction across low- and high-income communities.

CHAPTER FOUR

TEST RESULTS: A SITE OF ACCOUNTABILITY

4.1 Introduction

One of the central responsibilities of a primary care physician is to report and interpret routine medical test results. In recent years, we have made significant progress in identifying ways that physicians can improve patient understanding of test results (Richard, Glasser & Lussier, 2017). However, one often overlooked aspect of reporting routine medical test results is establishing the etiology of any change in health status, and the implied attributions this carries regarding patient health behaviors. For example, elevated liver enzymes may indicate heavy drinking, elevated blood sugar in a diabetic patient may indicate not taking medications as prescribed, and high blood pressure may indicate a lack of exercise or a diet in need of change. In this chapter, I examine instances in which a physician or patient orients to a test result as medically problematic (a ‘problematic test result’ indicating a ‘problematic health outcome’) and I ask how physician and patient then manage explicit and implicit attributions of fault.

This chapter addresses a puzzle: How do physicians navigate reporting and interpreting problematic test results, when by doing so they must relevantly take a stance on patient accountability over behaviors that may or may not be contributing to the problematic health outcome? What are the affordances and limitations of common physician approaches to discussing problematic test results? What do these patterns tell us about modern patients’ orientations to physician intervention in health behaviors such as diet and exercise? In addressing these questions, I examine physician and patient reports of problematic routine medical test results, all of which could be attributed to health behaviors. Most frequently, these are reports of lab results, weight checks, and home health tests (e.g., blood pressure readings). I examine all references to health

behavior, including any references to future or past behavior, regardless of whether the physician orients to this behavior as problematic, in order to evaluate how patients respond to a variety of physician attempts to discuss health behaviors in this context.

4.2 Background

Sociologists have long recognized the consequences of communities, institutions and individuals holding adults *personally responsible* for their health conditions (Timmermans & Tietbohl 2017). On one end of the healthcare spectrum, researchers have examined physician and patient perspectives regarding widely recognized stigmatized medical conditions. One survey found that physicians and nurses working in a general hospital considered patients with eating disorders largely responsible for their condition, to the same extent as those who recurrently overdose (Fleming & Szumukler 1992). Individuals with lung cancer report feeling unjustly blamed for their illness in interactions with oncologists and hospital administrators regardless of whether or how much they smoked in their lifetime (Chapple, Ziebland & McPherson 2004). People living with HIV/AIDS still perceive considerable stigma from healthcare providers in the United States, and this discourages these patients from accessing needed care (Kinsler et al 2007). These studies indicate that patients do recognize when physicians treat them as responsible for their medical condition. This impacts not only their perceived quality of care, but their propensity to seek follow-up and preventive care (Kinsler et al 2007).

On the other end of the healthcare spectrum, there is research examining physician and patient perspectives regarding stigmatized conditions that are a contested part of the medical domain. Obesity is a central topic in this area (Bombak 2014). In one study of nurses working in community hospitals in the 1990's, over half reported that they believed obesity could be prevented by self-control and they perceived obese patients as overindulgent and lazy (Maroney & Golub

1992). Today, not much has changed - two in three medical students exhibit explicit weight bias when presented with an anti-fat attitudes questionnaire; three in four exhibit implicit weight bias when provided with a test of automatic, unconscious attitudes about weight (Phelan et al 2014). The contested nature of weight as a medical condition (Conrad & Barker 2010) is especially visible in research in the reproductive healthcare setting. OB-GYN practitioners, including those with the fewest weight-stigmatizing attitudes, tend to respond more negatively in the healthcare consultation to women who are overweight or obese (Mulherin 2013). Pregnant women recognize and recall both overt and covert experiences of obesity stigma in reproductive health settings (Bombak, McPhail & Ward 2016). The same study also found that women routinely interpret practitioners' focus on fetal risk and "mother blame" for obesity as discriminatory. Obesity stigma (Mulherin et al 2013) in the healthcare setting impacts patients' health behaviors including diet (Raves 2016) and seeking follow-up and preventive care (Drury & Lois 2005).

Having high blood pressure, high cholesterol and high blood sugar levels all increase the risk of cardiovascular disease (Greenland et al 2003) – currently the number one cause of death in the United States (Lloyd-Jones et al 2010; Heidenreich et al 2011). Physician supervision of a patient's diet, exercise, smoking and other behaviors is more widely accepted on the basis of a diagnosis of hypertension, hypercholesterolemia, and pre-diabetes versus obesity. At the same time, these measures can vary widely and the patient's age, health status and family history all impact the probability of the condition triggering a serious health complication such as heart disease, heart attack or stroke (Hankey 2006; Greenland et al 2003). In this sense, orienting to a patient as personally responsible for a *medically problematic test result* lies somewhere between an orientation towards personal responsibility for experiencing obesity and a personal responsibility for developing heart disease. While reporting routine test results is a central part of

providing primary care services (Woodwell et al 2002), little attention has been paid to whether and how physicians orient to patients as having contributed to these health outcomes.

Patients' beliefs about the effects of their health behaviors often do not align with physicians' beliefs. For example, many adults believe hypertension is principally caused by stress and may stop pharmaceutical treatment during periods of low stress without consulting their doctor (Marshall, Wolfe & McKevitt 2012). Meanwhile, physicians recognize a wide variety of factors as contributing to hypertension, including intake of sodium and potassium, tobacco use, lack of exercise, age, family history, poorly controlled sleep apnea and medication nonadherence (Peppard et al 2000; Sacks et al 2001; Niskanen et al 2004). Many adults, when asked to compare two food products with identical nutritional information, believe one product to be *less healthy* based on characteristics beyond nutrition, for example where the food was purchased, whether the food is canned or frozen, and whether it is a recognized name brand product (IFIC 2018). Patients' beliefs about health management are not necessarily what doctors would expect and, not surprisingly, these beliefs shape patients' health behaviors (Paquette 2005).

Individuals also hold varied perspectives about the extent to which they believe their health condition *should* be framed as biogenetic versus behaviorally dependent. For example, many individuals experiencing an eating disorder report that medical professionals could reduce patients' feelings of blame and guilt if they framed the condition as biogenetic, while many others report fears that medical professionals would hamper recovery and damage patients' sense of control over their condition if they framed the condition as biogenetic (Easter 2012). Findings such as these highlight the barriers patients and physicians face when grappling with issues of fault and accountability when diagnosing hypertension, pre-diabetes and other common conditions.

Conversation analytic research indicates that physicians often do more than just *diagnose a condition* when they produce a diagnostic utterance. Diagnosis can be treatment-implicative (Stivers 2007) or serve as a justification of a physicians' actions (Heritage & McArthur 2019), among other things. Talk about diagnosis can also be closely tied to talk about health behaviors when patients and physicians work to establish etiology. Conversation analysts have studied how patients manage epistemic imbalances when making attributions for their cause of illness (Gill 1998) and the extent to which physicians respond directly to patients' attributions (Gill & Maynard 2006). Patients are seen to initiate disclosure of a medically problematic behavior to propose an etiology of a diagnosis in a variety of interactional contexts (Bergen & Stivers 2013). Similarly, physicians' questions about health behaviors can do more than just solicit information. In the context of psychotherapy, for example, questions about patients' alcohol use can highlight elements of a patient's narratives about alcohol for the purposes of promoting patient recognition of their behaviors as symptoms of an addiction (Halonen 2006). In this way, questions about health behaviors can promote a diagnosis.

Providing evidence of a diagnostic theory can also be a central component of establishing a diagnosis. Physicians treat themselves as accountable for the evidential basis of a diagnosis in primary care, as can be observed through the design and placement of their diagnostic utterances (Peräkylä 1998). Physicians can also address a lack of evidence of the diagnostic theory as problematic (McArthur 2019). When physicians provide online commentary early in the consultation, they also routinely use the physical examination to provide implicit or explicit evidence of the diagnostic theory (Heritage & Stivers 1999). Patients even draw on symptomatic evidence when providing candidate diagnoses (Stivers 2002). The role of evidence in the formation of the diagnosis can also be more interactionally complex. As mentioned earlier, Halonen (2006)

examines how psychiatrists' questions expose the extent to which patients recognize their own personal narratives about alcohol use as evidence of a diagnosis of addiction. The role of evidence in clinical interaction has been widely discussed in the conversation analytic literature. Approaching this topic from another angle, we can ask whether diagnosis is ever *used as evidence* for a secondary claim. One question addressed in this chapter is whether diagnosis (e.g., hypertension) or change in health status (e.g., rising blood pressure levels) can be used by physicians to establish evidence of a patient's medical misdeed (e.g., lack of exercise).

While the interactional production of a diagnosis (Heritage & McArthur 2019) and the phase structures surrounding diagnosis (Heritage & Maynard 2006; Robinson 2003) have been widely researched in Conversation Analysis, there has been less research on the reporting of routine test results. Comparing the phase structure of acute care consultations with chronic-routine Type II diabetes check-ups, Gelcich (2017) suggests that the blood-glucose check is best conceptualized as a part of the *examination phase* alongside the foot check and weight check, as opposed to a part of the *diagnostic phase*. She shows that patients and nurses orient to the blood-glucose check as a monitoring examination and do not treat it as diagnostic information. Likewise, the reported test results analyzed in this chapter are typically treated as markers of change (e.g., blood sugar levels are rising) and do not generate a first-time diagnosis of a medical condition (e.g., first-time diagnosis of diabetes). Examining video-recorded blood pressure/temperature readings, Pomerantz and Rintel (2004) show that physicians' reports unavoidably implicate expectations regarding the patient's knowledge and expertise – evidenced by the extent to which they interpret or explain the readings to the patient.

The interactional landscape in the healthcare consultation is complex. When studying physician and patient orientations towards patient accountability for health outcomes, there is no binary

approach. Physicians don't make explicit claims regarding patient accountability, and patients don't take one consistent stance on accountability. Though this reality poses analytic challenges, it also reveals important information about when and how institutions frame individuals as personally responsible for their health conditions, as well as how patients respond to these implicit claims. The analysis that follows explores how physicians and patients negotiate personal responsibility for health conditions

4.3 Data

This chapter relies primarily on a collection of 28 instances in which a primary care physician reports a medically problematic test result. I examine physician and patient negotiation of personal responsibility for changes in health status associated with everyday health behaviors including exercise, diet, smoking, alcohol use and medication adherence. As such, in this collection, I include physician reports of blood pressure checks, weight checks and routine bloodwork results (e.g., cholesterol, blood sugar). I do not include physician reports of results of *diagnostic testing* (e.g., x-ray, electrocardiogram). The focus of the chapter is on physician-patient conversations about health behaviors in the routine preventive care context, not a specific diagnostic context. I also do not include physician reports of test results that the physician orients to as non-problematic.

Cases were all coded for whether the physician solicits a report of current health behaviors and whether a patient provides a report of current health behaviors following the problematic test result, as will be discussed in detail in the next section of this chapter. To identify instances of patient disclosure and physician solicitation, I examine talk immediately following the report of the problematic test result on the topic of the newly exposed health issue. This may include any explanation of the result, review of prior test results, description of the health issue, proposal of

etiology or diagnosis, and indication of treatment. I include all talk up until the physician or patient initiates a topical shift away from the health issue. Typically, this transition involves a physician presenting the ‘next test result’ on the list of bloodwork results. I do not include instances in which physician or patient *return* to a discussion of the test result after intervening talk.

For a summary of the dataset please refer to Chapter 1. For a discussion of patient-initiated and physician-initiated disclosure of medically problematic behavior see Chapter 3.

4.4 Analysis

Examining how physicians and patients negotiate *personal responsibility* for common, unremarkable changes in health (e.g., increasing cholesterol levels) can reveal patients’ orientations towards the legitimacy of *medically problematic test results* as a basis for physician supervision over, and intervention in, everyday health behaviors. I ask, do physicians and patients systematically draw a connection between health behaviors and problematic routine test results in this interactional context?

After reporting a medically problematic lab result such as high blood pressure or rising liver enzymes, physicians do not treat the patient’s past behavior as relevant to the current results in 25% of cases (N=7 of 28), but instead present information about health behavior as new information or newly relevant information. In this way, physicians establish a future accountability over health behaviors that may impact the health outcome. In 39% of cases (N=11 of 28) physicians do treat past patient health behavior as a potential contributing factor (etiology). They typically draw this connection by soliciting a report of health behavior which typically results in a patient disclosure of a problematic health behavior. In these cases, physicians establish both past and future accountability for health behaviors associated with the health outcome. In the next two sections of analysis, I provide a more detailed overview of patient responses to these two physician

orientations towards patient accountability. Finally, I discuss the 36% of cases (N=10 of 28) in which patients initiate disclosure of a medically problematic behavior in direct response to the physician's report, thereby pre-empting the physician adopting a stance towards their past health behavior. I discuss how patient orientations towards accountability for problematic routine test results expose normalized assumptions about an individual's *personal responsibility* for managing their health.

4.4.1 The Physician's Orientation towards Patient Accountability

To frame this analysis, I provide a brief description of physicians' two primary approaches to addressing patient behavior following the report of a problematic test result. Case 1 provides an example of an instance in which the physician sidesteps holding the patient accountable for past exercise habits, while still establishing future accountability over exercise as it relates to the problematic health outcome. The transcript opens as the physician is reviewing the patient's routine bloodwork. He is reporting the patient's A1C (blood sugar) level, which he assesses as "good" (line 1).

Case 1 (0207)

1 Doc: I wish everybody was at a hundred. So: one hundred is good.
 2 Alright? So::.. Ah Has your weight changed by the way Tommy.
 3 Pat: N::o,
 4 Doc: No? Okay. Exercise level i::s,
 5 Pat: Very good.
 6 Doc: Very good. Okay. Ah:: your liver function. Completely normal.
 ...
 30 Doc: The g^{ood} cholesterol .h uhm: (.) went down just a little
 31 bit. The good cholesterol we like to see mo- as much as
 32 possible. I like to see generally above forty,
 33 Pat: Yeah. ((nod))
 34 Doc: Um I think, I- and yours is (.) right at the border, You're
 35 at thirty seven.
 36 Pat: Okay. ((nod))
 37 Doc: Okay, [So
 38 Pat: [That's al[right. ().
 39 Doc: [not (.) not terrible. Right, It's always
 40 been kinda yeah. **A- And a little extra s- exercise.**
 41 **Exertional exercise. Y'know. By exertional we mean huffing**

42 and puffing type exercise.
43 Pat: Kay, ((nod))
44 Doc: That will impro:ve the HDL. If it's sustained over fifteen
45 twenty: minutes. .h Of ah heart rates that are generally
46 above one ten one twenty?
47 Pat: Yeah. ((nod))
48 Doc: Uh for at least three four times a week? I think we- tho:se
49 are the types of gains that we'll see, .h that will impro:ve
50 the HDL on its own.
51 Pat: Okay.
52 Doc: Mokay? So: um So right now at this point in time, .hh Dou uh a-
53 and also medication of course will improve [the HDL as well.
54 Pat: [Mhm,
55 Doc: Uhm: do we need to change anything from what we're doing
56 right now? I think we should stay the course.
57 Pat: Okay, ((nod))
58 Doc: I think at this point in time.=You seem to be .hh doing very
59 well overall. So uhm, (.) Any questions.
60 (0.5)
61 Pat: .tlk .hh Uhm: no. [ah::
62 Doc: [Okay.

After reporting and assessing the A1C results, the physician gazes directly at the patient and begins to turn to the next page of the report. During this transition, before turning to look at the next page of the report, he asks the patient if his weight has changed (line 2). In this context, the question is *not* hearable as establishing etiology for the blood sugar because the blood sugar levels have not changed since the last consultation (transcript not shown) and are assessed as non-problematic (line 1). Rather, it is hearable as a history-taking question. The patient provides a minimal interjection answer, reporting no change in weight (line 3). The physician then solicits a report of the patient's exercise levels (line 4), again hearable as a history-taking question in light of the patient's prior no-problem response. The patient reports that his exercise levels are "Very good" (line 5). The physician repeats the assessment and accepts the patient's report (line 6). He then shifts his gaze to the chart and continues reporting the lab results.

After reviewing another page of the lab results (transcript not shown), the physician reports that the patient's "good" HDL Cholesterol has gone down (lines 30-31). He then explains what he sees as a 'healthy' level of HDL Cholesterol (lines 31-32), orienting to this as informative for the

patient. At line 33 the patient agrees with the physician's description of 'healthy' cholesterol, implicitly claiming prior knowledge of the meaning of cholesterol levels (see Stivers, Mondada & Steensig 2011). Regardless, the physician continues presenting information about cholesterol (and the links between exercise and cholesterol levels) as new information.

At lines 34-35, the physician provides the HDL Cholesterol level, and makes an assessment of it ("right at the border"). The patient then makes his own assessment of the cholesterol level ("That's alright"), again implicitly marking prior knowledge of the meaning of cholesterol levels. The physician continues to orient to the patient as receiving new news as he moves forward to imply that exercise will improve his cholesterol levels (lines 40-41). He even goes so far as to explain the meaning of "exertional" exercise to the patient, all presented as new information (lines 41-42). In this way, the physician frames the change in cholesterol as *a reason to* increase exertional exercise, as opposed to *caused by* any lack of exercise in the past. The patient responds with acceptance (line 43).

The physician then asserts that exercise will improve HDL Cholesterol levels, and describes a basic cardiovascular exercise regimen (lines 44-46, 48-50). Again, this is presented as new information. The patient responds with agreement (line 47) and acceptance (line 51). The physician asks whether the patient has any questions at line 30 – a closing-implicative question that anticipates a no-type answer. The patient confirms having no questions, and the physician produces a sequence-closing third (Schegloff 2007).

The patient's health status and his talk at lines 5, 33 and 38 suggests that this patient is aware that exercise impacts cholesterol levels, and that 15 minutes of cardiovascular exercise 3-4 days per week is medically advisable. Nonetheless, he responds to the physician's presentation of this 'new information' with immediate acceptance, agreement and engagement with the underlying

project of facilitating behavior change. Though the health issue at play is chronic-routine, the physician still frames this change in health status as a *reason for* future behavior change, as opposed to *caused by* past home health behaviors. Ultimately, the physician does not look backwards here, and does not orient to the patient's prior exercise behavior as problematic or even relevant at lines 30-62. The patient, in turn, accepts each 'new' recommendation for behavior change, and does not respond with displays of prior knowledge at lines 43, 47 or 51.

Case 1 provided an example of an instance in which a physician does not hold the patient accountable for past health behaviors while outlining a treatment plan that involves establishing new health behaviors. Still, the physician takes a stance on patient accountability but in this case the stance is that the patient is accountable moving forward.

Physicians can hold the patient accountable for *past* health behaviors while discussing etiology and treatment for a problematic health outcome. Case 2 provides an example of this. In Case 2, the patient solicits a report of weight gain (lines 2-3), then proposes an alternative SSRI when the physician asserts that the patient's current SSRI may be "allowing you to hold on to weight" (line 50).

Case 2

1 Doc: So here's your imaging here specifically:,
2 Pat: So. I gained a little weight, How- Can you just tell me how
3 my weight (.) was, (.) and how it's c- tracking, cause (0.5)
4 I'm sure I (.) put on five pounds.
5 (2.5)
6 Pat: Now I'm thinking that I'm [just-
7 Doc: [Your weight (2.0) today? Was two
8 ninety five,
9 ...
21 Doc: Twenty pounds in five months.
22 (1.0)
23 Pat: That's huge.
24 (2.0) | ((physician nodding))
25 Pat: Why: am I gaining that weight.
26 Doc: **Are you (.) eating (.) too much? Are you not exercising?**
27 Pat: I'm not exercising, I am [eating, But-
28 Doc: [Well that's-

29 Doc: Now remember that for (.) every pound that you: (.) gain or
 30 wanna burn off it takes thirty-five hundred calories.
 ... ((physician explains calorie counting))
 41 Pat: Well I think the reality is (.) One, (.) I'm I'm just eating
 42 too much for the amount of (.) exer- you know- for
 43 [what I'm doing and,
 44 Doc: [Exactly. .hh There's no magic to diets. It's what comes in,
 45 has gotta come out.
 46 (1.0)
 47 Pat: Yeah.
 48 (1.5)
 49 Doc: And if you're not doing it? (.) **And? plus the medications**
 50 **that you're on are probably allowing you to hold on to weight**
 51 **as well. Esp[ecially the Abilify: and things,**
 52 Pat: [Well. You know. I-
 53 Pat: ((sigh)) Well there's the question. It's when I was on: ah
 54 .hh I wasn't gaining weight when I was o:n a regimen of
 55 uhm: (2.5) ((sigh)) what's it called uhm: (3.0) Cymbalta.
 56 (1.0)
 57 Doc: Mhm,
 58 Pat: And it was just as effective.

At lines 2-3 the patient requests a report of his weight logs, citing a belief that he “put on five pounds”. When the physician doesn’t immediately respond, the patient begins what may be a candidate explanation or account, but cuts himself off when the physician speaks in overlap (line 6). The physician speaks over the patient, doing the math out loud (lines 7-8, transcript not shown).

At line 21, he announces that the patient has gained twenty pounds in five months, much higher than the patient’s estimate at line 3. The patient assesses the health outcome as “huge”, and the physician displays agreement with a long nod (lines 23-24). The physician does not speak for two seconds and the patient initiates a transition to establishing etiology. The physician asks the patient whether he is eating too much or not exercising, indicating that these two health behaviors could have contributed to his weight gain. In this way, the physician orients to the patient as accountable for his past health behaviors as they impacted his weight gain.

The patient confirms that he is not exercising and implies that he is eating too much (line 27). The physician then goes on to explain calorie counting and emphasize that “what comes in, has gotta come out” (lines 29-30, transcript not shown, lines 44-45), thereby outlining a treatment

plan (next steps). During this time, the patient acknowledges and agrees with the doctor (transcript not shown) and begins to make a list of causes of the weight gain, the first being that he is “eating too much” relative to his exercise levels (lines 41-43). However, before the patient can get to the second part on the list, the physician speaks in overlap with the patient, continuing with the treatment plan (lines 44-45). The patient responds with a minimal agreement (not acceptance) and there is a long silence (lines 46-48). The physician then shifts gears and presents a second etiology for the weight gain – presented as a secondary contributing factor (“plus”, “as well”). He doesn’t orient to the medications as causing weight *gain*, but rather as “allowing” the patient to “hold on to” weight gained through lack of exercise and diet. In this way, the physician continues to hold the patient accountable for past health behaviors (diet and exercise) while also discussing the effect the antidepressant Abilify may be having on his weight gain.

The patient speaks in overlap, backs off, loudly sighs, and asserts “there’s the question” (lines 52-53) indicating that he had previously considered this as a potential etiology for his weight gain, and that this was in fact the etiology that he aimed to discuss with the doctor. He then reports that he did not gain weight on an alternative antidepressant medication, yet that it was just as effective (lines 53-55, 58), thereby initiating a treatment negotiation. Case 1 and 2 demonstrate the two very different physician approaches to discussing health behaviors in the context of reporting problematic lab results. As we see throughout this chapter, physicians typically take one of these two approaches in their discussions of problematic lab results.

To reveal patients’ orientations towards physicians’ use of *medically problematic test results* to initiate discussions of behavior change, I move on to an analysis of how patients respond to physicians when they do versus don’t hold patients accountable for *past behaviors* that may have impacted their test results. I begin with an analysis of cases in which physicians *do not* orient

to patients' current or past behavior as problematic or a contributing factor. I discuss how patient responses to physician treatment plans in this context expose normalized assumptions about the patient's and physician's roles in managing health-relevant behaviors.

4.4.2 Accountability over Future Health Behavior

In a minority of cases, physicians *don't* orient to patients as accountable for past behavior that may have contributed to the problematic test result. Nonetheless, they do hold patients accountable for *future* health behaviors, as outlined herein. As we saw in Case 1 above, physicians typically sidestep implications of past patient accountability by presenting information about health behaviors as *new* or *newly relevant*. Importantly, presenting information in this way is not limited to new or dramatic changes in health status. For example, in Case 1 the patient's cholesterol is elevated but remains just within normal limits, and the patient displays prior knowledge about cholesterol readings. Patients don't respond to physicians presenting "new" information here by claiming prior knowledge (as is often done in other contexts) but rather they respond by accepting physicians' recommendations, agreeing with physicians' assessments, and otherwise committing to recommended behaviors. Patient responses tend to be minimal and single-TCU.

Physicians at times orient to information about health behaviors as *new* or *newly relevant* to the patient, as we saw in Case 1. Case 3 provides another example of an instance in which the physician orients to his recommendation for dietary change as newly relevant for the patient. In this instance, the physician reports that the patient's triglyceride levels are elevated during a review of a routine blood panel. He then transitions immediately into establishing a treatment plan and identifying a behavioral factor (diet) that is known to contribute to elevated triglyceride levels. The patient's first language is Spanish, but she is fluent in English.

Case 3

1 Doc: Next thing we look at is the trigicidérios. Triglycerides.
triglycerides

alternate health behavior made *newly relevant* by her problematic health outcome. The patient responds with a continuer (line 16) and laughter after the physician continues his list in Spanish (line 18). Physician and patient continue discussing diet for almost a full minute, as the physician lists foods to avoid and the patient talks about trying to cook with quinoa.

In both Case 1 and 3, patient responses include agreement, acceptance, and continuers. Patients sometimes respond in other ways, but patient responses in this context are consistently brief (single-TCU) and perform primary actions like agreeing with the physician or committing to the recommended behavior. In Case 4, the physician has just informed the patient that she has clinical markers for arthritis. As the transcript opens, the physician is explaining that arthritis can often cause additional swelling of the joints, on top of the natural swelling that warm weather can cause (e.g., in the summertime).

Case 4 (0211_labs1)

1 Doc: So just so you know. You may have a more exaggerated response
2 in terms of your .h water- your swa- your water accumulation
3 .h or uhh s- swelling in the summertime. So just to let you
4 know. **Salt is goнна be your enemy. Don't, (.) let salt into**
5 **your body,**
6 Pat: I ain't use salt, ((head shake))
7 Doc: Good. Okay. Alright. [.hh A:nd
8 Pat: [W- Would it be:: (.) a- advantageous to
9 just contine taking water pill:s?

The physician begins with “just so you know”, treating the subsequent talk as new information, given the patient’s test results. When he asserts that salt is “gonna be” her enemy, he uses future tense, thereby treating the patient’s future behavior as accountable and orienting to her past behavior as non-relevant. He treats the recommendation as *newly relevant*. However, this patient has had high blood pressure for years – for which limiting salt is a first-line treatment. The physician then directs the patient to not “let salt into your body” (lines 4-5). Again, this treats her as accountable for future dietary behavior but does not treat past behavior as clinically relevant here.

In response, the patient volunteers that she doesn't use any salt. This straightforward, single-TCU report of her current behavior performs multiple functions. It displays a commitment to do as the physician recommends, it displays agreement with the physician's recommendation insofar as it is something she was already choosing to do, and it is closing-implicative insofar as it treats salt intake as a non-issue. The doctor responds with a minimal positive assessment, sequence-closing third and acceptance, closing the directive sequence. The patient then asks a question – topically relevant as it addresses the treatment plan, but not an expansion of the prior sequence (lines 8-9). In this way, both the patient and physician work towards a forward progression of the consultation, discussing home health behaviors in this context.

The minority of cases in which a problematic lab result is reported involve physicians *not orienting* to patients as accountable for past behavior. These physicians typically treat information and recommendations as new, or newly relevant. These cases are characterized by a lack of patient resistance, even on the grounds of prior knowledge, and a forward progression and closing of the sequence. These findings indicate that patients orient to recommendations for widely-recognized 'healthy behaviors' such as regular exercise as non-problematic in the context of reports of a medically problematic lab result. Patients move forward through these sequences with an orientation towards progressivity and no visible resistance, even on epistemic grounds. But what about cases in which physicians *do* hold patients accountable for their past behavior? We will examine this question in the next section of analysis.

4.4.3 Accountability over Past Health Behavior

More often, when reporting problematic test results, physicians orient to patients' past behavior as a potential contributing factor to the problematic health outcome. Physicians typically display this orientation by soliciting a report of a health behavior following the test result (N=10

of 11). In one case, the physician addresses a behavior the patient had disclosed earlier in the consultation. Most patients respond with a report of a medically problematic behavior, hearable as a disclosure (N=8 of 10). Chapter 2 and Chapter 3 of this dissertation discuss patient disclosure and subsequent physician advice in detail. Here, I ask *what disclosure reveals* about patients' underlying assumptions and preferences regarding accountability for a health issue. I find that patients do not resist physician's requests for information about health behavior in this context, though they may resist physicians' subsequent *responses* to disclosure.

Consider Case 5 and 6, two comparable instances in which a patient discloses medication nonadherence after a routine blood test revealed high cholesterol. A side-by-side analysis of these cases highlights the consistency of patterns in patient response to physician solicitation of reports of health behaviors in this context. Case 5 and 6 take place in two different healthcare centers in two different communities. In Case 5, the physician is explaining the patient's bloodwork from a recent visit to the emergency room when he reports that the patient's cholesterol levels are "pretty high" (line 1). The assessment "pretty high" treats the test result as problematic. Relevantly, the patient has disclosed missing his heart medications earlier in this consultation.

Case 5 (0304_3)

1 Doc: Uhm: (0.3) your chol^esterol:, (0.5) .hhh is: pretty high.
 2 Pat: Uh.
 3 Doc: Again. Uhm:,
 4 (5.0)
 5 Doc: **Now. Do you forget to take your cholesterol medicine,**
 6 (0.5)
 7 Pat: Ah no, (.) yeah. sometime I do [I do. I do forget to take
 8 Doc: [Okay.
 9 Pat: my [cholesterol medicine.
 10 Doc: [^Alright.
 11 (0.5)
 12 Pat: Ah cause I be so concentrated on my heart, the blood pressure
 13 and stuff like that I do f-

Although the physician's informing at line 2 does not specifically make relevant response, response is invited and absent. There is also no clear uptake and after the physician's re-completion

at line 3. When no response is given for a full five seconds (line 4), the physician transitions to establishing the etiology of the test result, soliciting a report of whether the patient is currently taking his cholesterol medication as prescribed (line 5). By soliciting information about cholesterol medication here, the physician puts forward ‘missing cholesterol medication’ as a potential account for the high cholesterol. The question is not optimized (Boyd & Heritage 2006) but instead contains a grammatical preference for a yes-type answer that would disclose medication nonadherence. The question is a straightforward interrogative, not prefaced or accounted for. In this way, the physician displays an orientation to the question as fitted to the context. The design facilitates an answer that discloses non-adherence.

At lines 7/9, the patient provides an answer response that does not resist the question or its underlying project (establishing an etiology for the high cholesterol). He does orient to the socio-medical preference for a no-type answer by providing the socially preferred answer before reversing that answer and then mitigating it to “sometimes”, in the course of the turn, disclosing medication nonadherence (Pomerantz & Heritage 2006), but this is distinct from treating the question itself as problematic. Though he orients to his response as socially dispreferred, he still discloses nonadherence straightforwardly and without resistance. The patient then accounts for his nonadherence, saying he forgets to take the cholesterol medication because he is so focused on managing his other chronic health issues (lines 12-13). In this way, he provides information about the circumstances surrounding his behavior that were not directly requested, but may help the physician understand the patient’s behavior and consider his next steps.

Case 6 takes an almost identical trajectory to Case 5. The transcript opens as the physician reads the patient’s lab results and reports the patient’s cholesterol levels are “still hi:::gh” (line 1).

Case 6 (0623_1A)

1 Doc: .hh Your cholesterol is still hi:::gh.
2 (1.0)

3 Pat: M[m.
4 Doc: [It went from two sixty to two eighty eight. And we want it
5 below two hundred.
6 (0.8)
7 Pat: Mm hmm.
8 Doc: **So. Are you taking your um (0.3) cholesterol medicine:?**
9 Pat: Mm mm. No.
10 Doc: You're not taking it.
11 Pat: I need to uhm: get a refill. Cause that one is old.

Following some silence and a minimal patient acknowledgement of the news about the lab result (lines 2-3), the physician further specifies her report, again orienting to the patient's cholesterol as medically problematic (lines 4-5). After further silence and another minimal acknowledgement (lines 6-7) the physician transitions to establishing the etiology of the result, asking the patient if she is taking her cholesterol medication as prescribed (line 8). The so-prefaced question is hearable as pursuing an agenda that was 'on the speaker's mind' during the prior talk (Bolden 2009). By soliciting information about cholesterol medication here, the physician treats 'missing cholesterol medication' as a potential etiology. As in Case 5, the question is an unmitigated interrogative, not prefaced or accounted for, displaying an orientation to the question as fitted to the context.

The patient provides a straightforward disclosure that does not resist the question or the project of establishing a reason for the rising cholesterol levels (line 9). The physician requests confirmation (line 10), and the patient accounts for her nonadherence, saying that she needs a refill of the medication (line 11). As in Case 5, the patient provides information about the circumstances surrounding her behavior without solicitation. The account gives the physician additional resources with which to address the patient's nonadherence.

The regularities exposed in an analysis of Case 5 and 6 hold across these data. Physicians treat their requests for patient reports of health behaviors as fitted to the context of establishing an etiology for a problematic health outcome. Physicians do not mitigate or qualify these requests in this context (N=10 of 10 requests). In addition, patients routinely account for their problematic

behavior when physicians solicit a report of health behavior *to establish etiology* for a test result (N=7 of 8 disclosures). In the one case in which the patient does not account for her disclosure, she backs off her disclosure by repeatedly minimizing it. When these patients do not include the account within the disclosure turn, they provide an account at the next opportunity space, as we will see in Case 7. These accounts are initiated by the patient, and occur either in the disclosure turn or following the physician's responsive agreement, acknowledgement, continuer or partial request for confirmation. Notably, these physicians do not need to make an explicit request for a report of the circumstances surrounding the patient's behavior to get this information.

Case 7 provides an example of an instance in which the patient does not account for her behavior during the initial disclosure turn, but does so following a request for confirmation of her behavior. In Case 7, the patient has just been informed that her weight, blood sugar, and cholesterol have all gone up in the past few months. There has already been some discussion of diet in this consultation. The patient's wife, who this doctor also treats, is currently on a diet.

Case 7

1 Doc: And the triglycerides have always been really good and then this
2 time the triglycerides were up too.
3 Pat: Yea:h. (It's like) ().
4 Doc: It goes hand in hand with diabetes. [Right, the triglycerides and
5 Pat: [((nod))
6 Doc: the (.) sugars, 'Cause it's ah- triglycerides are technically the
7 sugar and the fats (.) [together. ((nod)) in the [bloodstream.
8 Pat: [Fat. (). [Yeah. ((nod))
9 Doc: It's the first thing that gets made. Right. Triglycerides. So it
10 depends on if you eat something really fatty in comes: it goes up.
11 Pat: Mokay,
12 Doc: Are you guys eating at home mo:re?
13 Pat: °No:::°
14 Doc: ((nod)) You're still eating [out,
15 Pat: [Yeah- Well when we eat at home
16 **actually she: just eats protein shakes,**
17 Doc: Uh [huh,
18 Pat: [At home. And it's like ^Well: you kno:w there- h ((laugh))
19 **the(h)re are these oth(h)er (thing(h)s you can ea(h)t hh h.)**
20 Doc: Then (.) [Do you-
21 Pat: [But I'd say she's just very- [yeah.
22 Doc: [She's good about her
23 protein shakes, [Why- You can't do it?

24 Pat: [Yeah.
 25 Pat: .hhhhhh °Well?°
 26 (2.0)
 27 Doc: Or [it's-
 28 Pat: [>I could do that.< Yeah. Yeah. But I do:n't.=
 29 Doc: =I mean you d^id it befo:re with RFO:. [Right? I mean it was all
 30 Pat: [I know. I know.
 31 Doc: liquid diet [for a long time.
 32 Pat: [Yeah. Now they're- Now they're all made and
 33 everything. But it's kinda [like (.) Oh that's her food.
 34 Doc: [Y^es.
 35 Doc: So then you end up making yourself something to eat,
 36 Pat: Yeah. Yeah.
 37 (0.5)
 38 Pat: ^Actually I usually make a- a- (.) I usually make a s- s- a
 39 fruit (.) protein shake.
 40 Doc: Uh [huh,
 41 Pat: [But- But um Yeah: but uhm I think ah (.) our downfall's when
 42 we go out. °And I ()°
 43 Doc: Her leftovers. Right. Right yeah. .hhhhh O(h) [kay.
 44 Pat: [So: yeah: so it's
 45 like .h errr not good.
 46 Doc: And then ah you did your mammogram in March,

At lines 1-2, the physician reports that the patient's triglyceride levels have increased. The physician explains the meaning of the measure at lines 4, 6-7 and 10, orienting to the measure of triglycerides as a proxy for fat and sugar intake. At line 12, the physician initiates a discussion of the patient's current eating habits. The position of the question makes it hearable as considering eating habits as an explanation for the high triglyceride levels.

At line 12, the physician asks directly whether the patient and her wife have been eating at home more often. At line 13, the patient whispers a “no” type answer, showing hesitancy to disclose her dietary behavior. In response, the physician nods and makes a request for confirmation that the patient is still eating out, opening the floor for the patient to account for this behavior (line 14) (Raymond & Stivers, 2016). As we saw in Case 5 and 6, the patient orients to the circumstances surrounding her behavior as relevant here, and reports that her wife will only eat protein shakes when she eats at home – implying that she does not have support at home in preparing and consuming healthy, balanced meals. The physician attends to the patient's report, asking whether the patient can't also try her wife's protein shake diet (lines 22-23).

The patient responds by candidly expanding on the topic of liquid diet, hinting at the potential for behavior change (“I could do that”) but immediately pulling back from this hint (“But I don’t.”) The physician cites the patient’s previous attempt at an all-liquid diet (lines 29, 31). In overlap, the patient makes an explicit claim of prior knowledge, and reports that this same all-liquid diet is now sold in a pre-made form, implying that this diet is now easier to implement. However, she immediately follows this with some resistance to implementing this diet, describing the feeling that this diet is her wife’s territory. Key here is not whether the patient accepts or rejects the physician’s implied recommendation for behavior change, but rather that the patient engages with the discussion of home health behaviors in this context, providing additional details about the circumstances surrounding her health behaviors.

The physician continues to attend to the patient’s reports of the circumstances surrounding her dietary behavior and asks whether the patient prepares meals for herself when her wife prepares the diet shakes. The patient responds by describing the type of food she makes, and the physician responds with a continuer. The patient then initiates a topic shift, positing that the biggest impact occurs when she goes out to eat – returning to the physician’s initial question at line 12. The patient and physician close the sequence at lines 43-45.

When physicians orient to patients’ past behavior as a potential contributing factor to the problematic health outcome, patients do not resist reporting their problematic health behaviors, but do systematically initiate descriptions of the personal circumstances that surround their behaviors. Given the literature on patient reports of perceived stigma from healthcare providers in conversations about obesity and certain health conditions, we might expect patients to resist physician implications of accountability in this context. However, we do not see this here. Instead, patients spend significantly *more* time discussing health behaviors in these instances, relative to

instances in which physicians don't orient to patients' past behavior as a potential cause of their test result. They treat these reports as accountable, but they do not treat them as unfitted or inappropriate. These findings reveal a patient orientation towards the context of *reporting routine test results* as a context in which discussions of health behaviors and the circumstances of health behaviors *are* fitted. Notably, the physician's *basis* for requesting this information is a *specific measure of the patient's condition*, often established through a blood test or other laboratory test. This contrasts with an *ongoing diagnosis* such as lung cancer and a *contested diagnosis* such as obesity. Moreover, this orientation is not observed in all instances of physician-initiated disclosure. In the next section of analysis, I compare these disclosures with physician-initiated disclosures made in the context of routine history-taking.

4.4.4 Establishing Etiology

While patients routinely account for their problematic behavior when physicians solicit a report of health behavior *to establish etiology* for a test result, disclosures produced in response to other physician questions look very different. This provides additional evidence that patients' orientations to the relevance of a description of the circumstances surrounding their behavior is unique to the context of establishing an etiology for a health issue and not common across all instances of physician-initiated disclosure. For example, we can compare these to disclosures prompted by physicians' routine history taking questions – questions that are decidedly *not* built to link behavior to any new or ongoing health concern. Case 8 provides an example of one such disclosure. The disclosure occurs in the middle of the visit, as the physician requests information about the patient's sleep schedule and family history.

Case 8 (10.26.16C_4)

```
1      (19.0) | ((doctor typing))
2  Doc:  Are you- Do you have a certain type of exercise you like?
3  Pat:  Um: I've done running before::?
4  Doc:  Ah huh.
```

5 (0.3)
 6 Pat: Ah that's probably what I'd go back to:?
 7 Doc: Mhm,
 8 (0.5)
 9 Pat: Cause it's- I like things that are (.) accessible from home,
 10 [I don't have to: [go sign up for anything: or,
 11 Doc: [Right. [Go somewhere:, Right.
 12 (2.0)
 13 Doc: You're not running yet,
 14 Pat: **No. ((laugh)) I haven't started up yet.**
 15 (0.8)
 16 Doc: I- Any time I try to stop myself, I tell myself:, uhm Two
 17 miles even if- even you're a rea:lly slow runner a ten minute
 18 mile. Right, So [two miles is twenty mi^utes.
 19 Pat: [Mhm.
 20 Pat: Yeah.

As the transcript opens, the physician types information into the chart. She then looks up at the patient and begins to ask “Are you”, but cuts herself off and quickly starts again. She asks if the patient has a type of exercise she prefers, topicalizing exercise without making a report of current behavior conditionally relevant. The patient and physician briefly discuss the patient’s preference for running (lines 3-11). The patient orients to running as a preferred form of exercise, not a current form of exercise. She asserts that running is “probably what I’d go back to:”, thereby indicating that she is not currently exercising, though there is no explicit disclosure. The physician then requests confirmation that the patient is not “running yet” (line 13). The physician asks the question at line 2 during a history-taking phase of the visit, as a stand-alone request for information. In this way, the physicians’ questions at line 2 and line 14 are *not* hearable as linked to an etiology for a medically problematic health outcome. Earlier in the consultation, the physician did do a report of the patient’s lab results and informed the patient that her blood sugar levels have been going up. Key, however, is that she *builds* the questions at line 2 and line 14 as stand-alone history-taking questions, unlike the physician questions in Case 5, 6 and 7 above.

The patient responds with a straightforward interjection disclosing a lack of exercise (line 14). The patient then laughs, then specifies that she hasn’t “started up yet” indicating an interest

in future behavior change but not making a commitment to behavior change. Unlike the three cases discussed above, this patient does not provide information about the circumstances surrounding her lack of exercise here. The physician responds by describing one method she uses to keep herself motivated (lines 16-18). The patient provides some minimal acknowledgement (lines 19-20). The physician continues discussing motivation for more than a minute, asking the patient follow-up questions about the circumstances surrounding her lack of exercise (work schedule, etc.) as she pursues patient commitment to behavior change.

With only one exception, patients *did not* immediately account for disclosures made in response to a physician's history-taking question (N=9 of 10). The one exception was a humorous account, in which the patient told the doctor she was not exercising because she was "Lazy". We can compare Case 8 to Case 9. In both cases, physician and patient have a long-established primary care relationship. In both cases, the physician has earlier reported that the patient's blood sugar level has increased. However, in Case 9, the physician builds her question as seeking an etiology of the patient's problematic health outcome, as opposed to a routine history-taking question.

Case 9 (0603_1)

1 Doc: Are you stress eating? Are you- What are you doing. Cause you
2 were down better. Then it got a little worse, and now it's
3 even worse.
4 Pat: **You know what? Because: I stopped going to the gym. And I'm**
5 **gonna tell ya. That's what it is. I'm on the freeway. You**
6 **know,**
7 Doc: And that time that you coulda been: doing stuff. ((nods))
8 Pat: **Yea:h.**

Prior to the opening of the transcript, the patient attributed her rise in blood sugar to her stress levels, but the physician was resistant to this explanation. At line 1 she asks the patient if she is "stress eating", thereby linking the patient's attribution to diet, a health behavior that may have a more direct effect on blood sugar. She then reformulates her question to "What are you doing" soliciting a report of health behavior more broadly (line 1). The physician's question is not

mitigated or otherwise downplayed and it presupposes that something about the patient's behavior is causing the increase in blood sugar. The patient responds with the disclosure that she has stopped exercising, and twice attributes the increase in blood sugar to this ("Because:" line 4, "That's what it is" line 5). She then immediately moves into an account for stopping exercising. This provides additional information for the physician about the circumstances surrounding the patient's behavior. The physician acknowledges and builds on the patient's account (line 7) and the patient agrees (line 8).

Comparing Case 8 and Case 9, we can see evidence in Case 8 that the physician is hesitant to ask the patient whether she is currently exercising and treats this as a sensitive question (e.g., her re-start at line 2 and her request for confirmation at line 13 only after the patient implies not exercising and then there is a long silence). In Case 9, the physician asks the patient directly whether she is stress eating and what she is doing that could be contributing to her high blood sugar. While the physician's question in Case 8 presupposes a history of exercise, the physician's question in Case 9 presupposes that the patient has problematic home health behaviors. The patient in Case 8 simply discloses that she "hasn't started" exercising and indicates that she may change her behavior. The patient in Case 9 discloses that she "stopped" exercising, attributes this behavior to her rise in blood sugar, then accounts for the behavior, providing the physician with information about the circumstances surrounding her behavior. The differences between Case 8 and Case 9 are characteristic of physician-initiated disclosures in the context of routine history-taking versus discussing problematic test results.

While we might expect patients to be more forthright and detailed in their disclosures when they are prompted in the history-taking context, relative to the context of establishing etiology, the opposite is true. Physician-initiated disclosures in the history-taking context were more likely to

be mitigated, were less likely to be accounted for, and were shorter on average (i.e., involved fewer turn constructional units) when compared to physician-initiated disclosures in the context of explaining problematic lab results. These findings indicate not only that patients' orient to descriptions and accounts of health behaviors as fitted to this context, but that patients' orient to these extended accounts and descriptions as *uniquely* fitted to this context.

Looking beyond physician-initiated disclosures, we can also ask whether patient-initiated disclosures contribute to this claim. Next, I briefly examine regularities in patient-initiated disclosure in the context of reporting problematic test results.

4.4.5 Patient-Initiated Disclosure

In 10 of 28 instances in which a physician reports a medically problematic lab result, the patient initiates disclosure of a medically problematic behavior before the physician finishes describing the test result. In each case, the patient presents the disclosure as a candidate etiology, and the physician then orients to the patient's behavior as having contributed to the test result.

Case 10 provides an example of one such case.

Case 10 (0601_labs1)

```

1 Doc: Cholesterol was fantastic, Liver kidneys were all good. .hh
2      um Sugar:? I mean you're not diabetic by any means, It's a
3      li- little bit higher than [la(h)st time? ((laughs))
4 Pat:                                     ((nod))
5 Pat: Kay. Yeah.
6 Doc: I mean we're inching:, [ever: so:: slo:::w,
7 Pat:                                     [Right. Little- Little slow. I know
8 Pat: it's the holidays [(that did it,) ((laughs))
9 Doc:                                     [It's the holidays:. I get it. We'll check
10      it after:.
11 Pat: Yeah. Next- Next time we'll do better.
12 Doc: Yea:h.
13 Pat: ((laughs))

```

At lines 2-3, the physician reports that the patient is not diabetic, but that his blood sugar levels have gone up. The patient nods and accepts the physician's report (lines 4-5). The physician then further describes the trajectory of the patient's blood sugar levels, emphasizing that his levels have

been on the rise and describing his readings as “inching:, ever: so:: slo:::w,” leaving unsaid that the diagnosis of concern is diabetes (line 6). At lines 7-8, the patient agrees and does a partial repeat of the physician’s description “slow”. He then asserts that the “holidays” caused this rise in blood sugar with “it’s the holidays that did it,”. In this case, the patient presents his own theory of the cause for the problematic health outcome and does so at a point where physicians regularly tie the result to a likely cause.

In response, the physician repeats the patient’s assertion, displaying agreement (line 9), and makes a display of empathy (Voutilainen 2010). She then articulates a treatment plan (next steps). Specifically, checking the patient’s blood sugar after the holidays, i.e. after the patient’s diet has improved. The patient agrees and states that they will be better (line 11). The physician agrees (line 12); the patient laughs (line 13); and the physician transitions into the next activity without patient resistance (transcript not shown). Although the patient’s diet is oriented to as the cause through the reference to “the holidays” and “blood sugar”, this is never articulated. Instead, the circumstances surrounding his dietary behavior (“the holidays”) are put forward.

In 36% of instances in which a problematic test result is reported, patients display a willingness not just to provide disclosures and descriptions of the circumstances surrounding their behavior, but to *initiate* a discussion of health behaviors as potential etiologies. This provides further evidence that patients orient to the context of *reporting test results* as a context in which discussions of health behaviors and the circumstances of health behaviors are fitted.

Up to this point, I have discussed how patient accountability is interactionally managed following the report of a problematic test result. The fact that patient accountability is implicitly or explicitly addressed following every report of a problematic test result is no coincidence. In the

final section of analysis, I ask why this is, and what this reveals about the activity of reviewing test results.

4.4.6 Treatment as the Relevant Next Action

In this section of analysis, I argue that patient accountability does not *sometimes comes up* in discussions of problematic test results, but is an integral *feature* of these discussions. There are two parts to this claim – one an analysis of regularities in physician and patient action, and the other a structural analysis of social action.

In these data, there are no instances in which a physician reports a problematic test result and then simply moves forward in the consultation with no discussion of next steps i.e., a treatment plan. Instead, physicians and patients transition directly from reporting and explaining medically problematic test results to discussing the treatment plan (i.e., behavior change, new medication, specialist care, or ‘watch and wait’). This is regardless of whether the test result warrants a formal diagnosis. The initial report and explanation of the test result may include describing the test result (see Case 2 line 21) assessing the test result (see Case 3 line 10), or providing a frame of reference (see Case 1 lines 31-32). Patients and physicians orient to establishing the treatment plan as part of the forward progression of the visit, and the relevant next step following the explanation of the medically problematic test result. Returning to Case 1, we can observe this mutual orientation towards progressivity by establishing a treatment plan. Following the physician’s provision of a frame of reference and description of the patient’s cholesterol levels (lines 30-32/34-35) the patient accepts the physician’s report and makes his own assessment of the cholesterol levels (lines 36/38). The physician then makes an agreeing assessment of the levels (line 39) and immediately transitions to an assertion-type recommendation (Stivers & Barnes 2017) for increasing exercise.

While many physicians do transition immediately from an explanation of the test result to establishing a treatment plan, as we saw in Case 1, other physicians and patients first do work to establish an etiology on which the subsequent treatment plan is based, and only then establish a treatment plan. This is where the ‘structural analysis of social action’ plays in. Whether a treatment plan only makes a bid for future change (thereby orienting to the patient as accountable for their behavior in the future but not in the past) or emphasizes past behavior that has contributed to the condition (thereby orienting to the patient’s past and future behavior as accountable) it is not structurally possible for a physician to recommend behavior change without orienting in some way to patient accountability over health-relevant behaviors. To examine this claim further, we can observe Case 11, in which a physician encounters patient resistance to her treatment plan.

As the transcript opens, the physician is reading the patient’s recent routine bloodwork. The patient was previously advised to take potassium tablets due to low potassium levels, though it’s unclear whether this physician initially gave her that advice.

Case 11 (0414_lab1)

```
1 Doc: Your kidney function is good,
2      (1.5)
3 Doc: Your potassium was a little high.
4      (0.3)
5 Doc: Um, [Are you taking potassium?
6 Pat:      [( ),
7 Pat: Yes I take it every da::y.
8 Doc: You shouldn't.
9      (0.5)
10 Pat: Why.
11 Doc: It's high.
12 Pat: But then- And then it'll be low.
13 Doc: ((laughs)) Uhm[:.
14 Pat:      [What's go[ing o::n.
15 Doc:      [What if you d- What if you do- It's
16 Doc: not that high. It's right, at the upper border of [normal.
17 Pat:      [Mmm.
18 Doc: Uh (.) How about if you take it every other day.
19 Pat: Okay.
20      (0.5)
21 Doc: Huh:, Let's [do that.
22 Pat:      [Alright.
```

At line 3, the physician reports a medically problematic test result, informing the patient that her potassium was “a little high”. When the patient does not immediately respond, the physician asks the patient whether she currently takes potassium supplements (line 5), potentially a pre-recommendation for altering her treatment regimen (Barnes 2018). The patient confirms with an interjection followed by a specification that she takes it daily. Her intonation makes the turn hearable as resistant to the physician’s pre-recommendation against potassium, possibly having to do with the fact that she was previously advised to take the potassium supplement.

The physician then advises the patient to stop taking the potassium supplement daily (line 8). The advice constitutes a treatment plan; however, it is not clear whether the physician is orienting to the patient’s prior use of the supplement as problematic. The placement of her recommendation indicates a theory that the daily supplement contributed to the patient’s high potassium level, but the patient’s prior turn was not a disclosure of a medical misdeed but rather an assertion that she is continuing to take the supplement as advised. At line 10, the patient actively resists the physician’s recommendation, asking her “Why” she shouldn’t, seeking justification of the recommendation and treating information as missing. The physician answers that the patient’s potassium level is “high” (line 11). However, the patient does not orient to this as sufficient information, again actively resisting the physician’s recommendation and countering that her potassium levels will then be low. The patient asks what is “going on”, explicitly soliciting an explanation that goes beyond a recommendation and holding the physician accountable for providing one.

The physician begins by proposing something, potentially a treatment plan, but cuts herself off twice (line 15). She then clarifies that the potassium levels are not “that high” and are at the border of the normal range. The patient responds with a minimal acknowledgement (line 16). The

physician then proposes that the patient start taking it every other day, instead of daily. By clarifying that the potassium levels are on the upper end of normal and that she is only advising the patient to cut down on the supplement, physician indicates that the high potassium is likely associated with taking the supplement *too frequently*. In this way, the physician clarifies that the patient's past behavior *was* contributing to the high potassium levels, but that the prior recommendation to take potassium supplements was not inappropriate. With this insight, the patient immediately accepts the recommendation (line 19). There is no further resistance to this treatment plan. By recommending a treatment plan when two conflicting orientations to etiology and therefore patient accountability are on the table, the physician pursues an activity that the patient resists on a basis of lack of information needed to respond to the treatment plan ("What's going on?" line 14). This provides additional evidence of the structural impossibility of recommending behavior change with no clear orientation to patient accountability.

4.5 Discussion

Examining patient reports of being held personally responsible for their health conditions, one could hypothesize that patients would be broadly resistant towards any indication of fault or accountability following a report of rising blood sugar levels, high cholesterol or another medically problematic test result (see Chapple, Ziebland & McPherson 2004; Kinsler et al 2007). Instead, these data show that patients orient to the context of *discussing problematic test results* as an environment in which talk of problematic health behaviors is uniquely fitted. When physicians orient to patients' health behavior as a potential contributing factor in this context, patients do not resist disclosing medically problematic behaviors. They treat these disclosures as accountable, but not unfitted or inappropriate. In fact, they spend more time discussing their health behaviors and providing descriptions of their personal circumstances when compared to conversations in which

the physician does not orient to the patient's past behavior as a potential contributing factor. They also display more markers of dereference when disclosing medically problematic behavior in the history-taking context, relative to the context of discussing problematic lab results.

The basis on which physicians request information about patients' current health behaviors is also relevant. Much of the current sociological literature examines cases in which physicians orient to patients as responsible for their health conditions on the basis of a stable diagnosis such as lung cancer or a contested diagnosis such as obesity. In contrast, in this chapter I examine cases in which physicians orient to patients as responsible for their health conditions on the basis of documented, mundane shifts in patients' health status (e.g., new bloodwork shows rising blood pressure). Chapter 2 of this Doctoral Thesis provides evidence that patients orient to behavior-change advice as relatively more acceptable when physicians frame their advice as treatment-relevant. In a similar way, by relying on a basis of a shift in health status to request information about health behaviors, physicians implicate treatment-relevance in their requests. Section 4.4.6 shows that establishing a treatment plan is oriented to as the relevant next step following the report and explanation of a problematic test result.

Sociological scholarship has explored the *consequences* of institutions and individuals holding adults personally responsible for their health outcomes (Chapple, Ziebland & McPherson 2004; Kinsler et al 2007; Bayer 2008; Burris 2008; see Timmermans & Tietbohl 2018). However, there has been limited research on *the ways in which* these institutions and individuals hold adults responsible for their health outcomes – and to what extent consequences are impacted by approach. This chapter demonstrates that patient orientations towards health behavior accountability are not static, but rather are socially constructed, malleable, and exist within competing activities and

priorities. These findings motivate further study of the social and interactional contexts in which addressing individual responsibility for health outcomes *is treated as* (in)appropriate.

CHAPTER FIVE

CONCLUSIONS

5.1 Theoretical and Methodological Contributions

5.1.1 The “Wellness Revolution” and the Primary Care Consultation

The pursuit of wellness has become one very few undisputed *paths of moral action* in our society (Gillick 1984; Becker 1986). Wellness is treated as a virtue in and of itself (Conrad 1994). This is reflected in the discourse in the media (Boero 2012), online social platforms (Lupton 2017), and even our workplaces (Kirkland 2014; McGillivray 2006). However, it is not clear to what extent this is reflected in the contemporary healthcare setting. What is the role of wellness in the primary care setting, and how is it related to the role of treatment? Routine primary care constitutes the vast majority of most people’s interactions with the American healthcare system, and it is where most routine preventive healthcare is provided. As such, it is often patients’ first line resource to get information discuss health and wellness behaviors with a medical professional.

Notably, Conrad (1994) demonstrated that wellness-seekers treated wellness behavior as a moral good in and of itself, regardless of health outcomes. They categorized their behaviors on a moral continuum and pursued those behaviors high on the continuum. However, the study reflected only individuals’ self-reported beliefs and furthermore the study’s subjects were primarily white upper-class college students. This dissertation contributes to our understanding of the “wellness revolution” (Conrad 1994) by examining how physicians and patients *orient towards* discussions of wellness activities versus treatment activities during the clinical consultation, across a diverse sample of primary care consultations.

Importantly, Chapter 2 demonstrates that patients don’t unilaterally accept physician’s lifestyle counseling, but rather differentiate between two types of behavior-change advice. Patients

overwhelmingly accept physician advice that is made on the basis of addressing a specific health concern. We can conceptualize this as *treatment advice*. In contrast, patients overwhelmingly resist physician advice that is made on the basis of a moral order – that one ‘should’ have a healthy lifestyle regardless of health condition. Interestingly, this resembles the moral order of wellness as a virtue outlined by Conrad (1994). As such, here I conceptualize this form of lifestyle counseling as *wellness advice*.

Ultimately then, Chapter 2 reveals that patients show a preference for behavior-change *treatment advice* and systematically resist behavior-change *wellness advice*. However, there is evidence that *physicians* routinely treat wellness behavior as a moral good in and of itself. For example, almost half of physicians’ behavior change advice is framed as wellness advice and is made on the basis of a moral order of the value of healthy lifestyle. This difference in patient and physician orientations to behavior-change wellness advice may reflect a standard in which physicians orient to wellness as a moral virtue but patients do not recognize physicians as having the deontic authority to promote wellness in the clinical encounter.

Literature on nutrition and chronic care management indicate that patients doubt their own health behaviors. However, they both trust and rely on lifestyle advice when it comes from medical professionals (IFIC 2018). Despite this, physicians perceive patient resistance to lifestyle advice broadly (Jansink et al 2010; Lambe & Collins 2010). The findings presented in Chapter 2 provide one account for this discrepancy. Patients *are* broadly receptive to behavior-change advice, but only when it is formulated as a treatment plan for a health condition. Their resistance is not in fact towards *lifestyle advice*, but rather towards *wellness advice*.

Due to the important role preventive and chronic care play in the primary care setting, framing lifestyle advice as wellness advice versus treatment advice is not dependent on the extent

to which a health behavior is objectively linked to diagnosis. Rather, it is simply dependent on whether the physician frames that behavior as linked to a specific health concern. For example, in one instance the physician frames her recommendation for exercise as treatment advice by indicating that increasing the patient's exercise will *stop her from moving towards diabetes*.

Chapter 4 demonstrates that patients are not only orienting to a preference for a basis of treatment over wellness in the context of behavior-change advice, but they are also orienting to this same preference in the context of the initiation of lifestyle discussions. Patients orient to the context of addressing a problematic medical test result as uniquely fitted to discussions of lifestyle. In this context, they frequently initiate disclosure and display a willingness to participate in non-minimal discussions about lifestyle, which contribute to the activity of promoting behavior change. In contrast, in the routine history-taking context, patients typically provide minimal and mitigated disclosures, displaying a hesitancy to disclose their behavior in response to these physician questions. Notably, the standardization of these routine history taking questions (e.g., *do you smoke*) is couched in an institutional orientation to a moral order of wellness as a virtue, insofar as these questions are asked of all patients regardless of the condition of their health.

These findings also have methodological implications, particularly for studies examining physician and patient *reports* of experiences with lifestyle counseling. Specifically, regarding how these studies define and operationalize lifestyle counseling in surveys, interviews, and data analysis. For example, when a survey question asks whether a physician perceives patient resistance to lifestyle counseling, researchers will benefit from an understanding that the term *lifestyle counseling* is not reflective of one activity type. Rather, a study of patient responses to lifestyle counseling indicates that it is reflective of two distinct activity types, treatment-implicative lifestyle counseling and wellness-based lifestyle counseling. In an analysis of variation

of patient responses to these two types of counseling, I establish in Chapter 2 that treatment-implicative behavior-change advice had a 72% rate of acceptance, whereas wellness-oriented straight behavior change advice had only a 17% acceptance rate. Moreover, patients responded to these two types of advice in qualitatively different ways, encoding a preference for treatment advice over wellness advice. Taken together, these findings suggest that future studies will benefit by acknowledging these two distinct forms of lifestyle counseling as uncovered by an inductive analysis of patient responses to behavior-change advice.

This, however, is only the beginning of the story. As mentioned above, the preference for treatment advice is entangled with changing definitions of *treatment* and the increasing prevalence of medical interventions couched in preventive care and chronic care activities. If patients are broadly orienting to *wellness* as a dispreferred basis for physician initiation of lifestyle discussions and advice, then where do they draw lines around preventive care, lifelong chronic illness management, and standard medical surveillance routines?

5.1.2 Everyday Surveillance Medicine

Research on surveillance medicine is often approached through a moral lens – the sense in which this social process “turns health into the moral” (Conrad 1992, 1987). In comparison, the findings presented in this dissertation hold up a mirror to the ways in which patients systematically respond to this social process in everyday situations. The expansion of surveillance medicine has been underway for decades (Schneider 1978). As such, our question is one of modern boundaries – what aspects of surveillance medicine patients accept and resist. This dissertation approaches this question in the context of the routine primary care consultation, examining mundane physician-patient discussions at the micro interactional level.

Routine bloodwork is one activity that reflects a systemic normalization of medical surveillance of *health measures*. Turning to a discussion of the contemporary transition from treatment of disease to long-term chronic and preventive care, these dissertation findings also speak to the question of how patients orient to the treatment relevance of minor changes in health as identified by routine bloodwork and other routine medical tests (e.g., rising blood pressure with no diagnosis of hypertension). In Chapter 4, I show that following any report of a mundane negative test result, both patients and physicians orient to the immediate relevance of establishing a treatment plan. These range from adjusting medication regimens, to advising health behavior change, to ‘watch and wait’ – but importantly, this activity is never passed over. This indicates that both patients and physicians orient to these reported negative changes as more than descriptors, but as clinically relevant in a similar way to the diagnosis of disease.

Addressing medical surveillance of *health behaviors*, and reflecting the discussion in the prior section, the findings presented in Chapter 2 and Chapter 4 indicate that patient response to instances of medical surveillance of health behaviors is highly varied, and dependent on the implied basis of the surveillance activity. In Chapter 4 I demonstrate patients treat physicians’ questions about their health behaviors as acceptable when these questions are hearable as working to treat the patient’s health problem. However, this form of lifestyle surveillance is not treated as acceptable if it is *not* clearly linked to a project of establishing a treatment plan.

Chapter 3 provides evidence that patients don’t just display acceptance of treatment-relevant medical surveillance, but also *rely on* the constructs of medical surveillance to pursue their own courses of action during the visit. In this way, the prevalence of surveillance medicine facilitates certain patient healthcare projects. For example, by upgrading a disclosure of a smoking habit, a patient can functionally upgrade a bid for a prescription for smoking cessation medications.

Chapter 3 provides an analysis of one such case, in which the patient subsequently makes an explicit bid for smoking cessation medications. However, this is only possible when there is a mutual acceptance of the assumption that smoking is *in itself* something that demands physician supervision and intervention. Importantly, there is also a class element to this – patients in high-income white communities pursued this type of healthcare project much more frequently than patients in low-income communities of color.

Stepping back, we can see that these findings contribute to a broader theoretical conversation about the academic discourses surrounding wellness and patient agency as well. Next, I turn to a discussion of frameworks of nonadherence and wellness in the academic literature on medical interaction.

5.1.3 Discourses of Nonadherence and Wellness

The fields of sociology and public health have historically approached research on nonadherence from very different perspectives. The public health literature on nonadherence typically examines the social reality of physician promotion of patient adherence, but does not critically examine physician and patient orientations towards nonadherence frameworks. In contrast, the sociological literature typically provides that critical examination, but relies on a theoretical formulation of the nonadherence framework. This dissertation contributes to a line of study of the *social reality of nonadherence*, thereby bridging these two approaches.

In an examination of the questions that prompt disclosure, Chapter 3 demonstrates that physicians most frequently *pursue reports of problematic behavior* in low-income communities of color. In contrast, they most frequently *request information about health behavior* in high-income white communities. Physicians working in these low-income communities also “pessimize” their questions about health behaviors, displaying higher rates of presupposition of problematic

behavior and lower rates of optimization. This reveals a difference in the pervasiveness of physician expectations of patient adherence to ‘healthy’ lifestyle practices across these two communities.

Returning to the prior discussion of displayed patient preference for treatment advice over wellness advice, we can examine how patient orientations towards nonadherence frameworks relate to their orientations towards wellness activities. In Chapter 4, I establish that when physicians treat patients’ past problematic behavior (i.e., nonadherence to ‘healthy’ lifestyle practices) as potentially contributing to a worsening of their health condition, patients not only initiate disclosure of medically problematic behavior, but provide non-minimal descriptions and expand on the personal circumstances surrounding their behavior. These findings contribute to an argument for re-examining the pervasive negative associations sociologists have built around nonadherence frameworks. This dissertation, situated in the *social reality* of American patients’ orientations towards the role of the physician and the goals of the clinical encounter, indicates that patients exert individual agency and respond positively overall when faced with physician problematization of nonadherence to ‘healthy’ lifestyle practices. In contrast, as discussed earlier, patients display considerable resistance towards wellness advice and health behavior discussions initiated on a basis of wellness promotion.

While the academic discourse *surrounding* “noncompliance” and even nonadherence may promote paternalistic ideals of medicine, in this study patients actually respond to physician problematization of nonadherence by exerting their agency sharing the circumstances surrounding their lifestyle choices and pursuing physician advice. As such, we do not see simplistic reflections of the academic discourse on the ground – physicians are not exerting authority to demand adherence, but rather are participating in a complex dance with patients, as they negotiate levels

of agency and authority. Notably, however, this dissertation only examines discussions of health behavior that the patient orients to as medically problematic. For example, a report of ‘occasional drinking’ which the patient frames as non-problematic (see Halkowski 2012) would not be examined in this dissertation.

5.1.4 Personal Responsibility and Agency

If activities built on a treatment or adherence basis facilitate patient agency and positive patient response, and activities built on a wellness basis promote patient resistance, where does this leave patient orientations towards personal responsibility for their health behaviors and health outcomes? Notably, both physicians and patients can tie personal responsibility to any activity, regardless of the basis of that activity.

In the routine primary care consultation, disclosures of medically problematic behaviors are not the delicate activities we may have imagined them to be. We can observe that patients aren’t always defensive, qualifying or mitigating their disclosures, even in response to physician questions that indicate the patient’s behavior contributed to their own decline in health (as we see in Chapter 4). Instead, patients upgrade their disclosures surprisingly frequently and use these upgraded disclosures to pursue projects including treatment negotiation and promoting behavior change.

Importantly, there is an observable class component to this. In Chapter 3, I show that patients in low-income communities of color do more positive self-presentation work when they disclose medically problematic behavior. In comparison, patients in the high-income white communities routinely upgrade their disclosures and cite them as *reasons physicians should intervene* e.g., with medications. For example, emphasizing that one hasn’t succeeded at quitting smoking or dieting to pursue a pharmaceutical intervention. This is a much more complex

orientation to, and use of, *personal responsibility* than we might expect. Patients do not simply act as passive recipients of blame and stigma, but rather may use a sense of personal responsibility over health outcomes to promote their own healthcare projects – to a greater or lesser extent across high- and low-income communities.

Overall, these findings demonstrate that at the site of the most routine intersection between lifestyle and healthcare, the issues surrounding wellness, nonadherence and patient accountability are far more complex than we might have previously understood. However, acknowledging these layers doesn't prevent us from establishing a systematic analysis of the social reality of this space. In addition, acknowledging these layers does not stop us from identifying clear clinical applications. To the contrary, studying these new layers will allow us to identify even more compelling, clear-cut applications and interventions. This is the discussion I turn to next.

5.2 Implications for Clinical Practice

The findings presented in this dissertation indicate that physicians are already providing a form of lifestyle counseling that patients respond very positively to, as evidenced by the rate of immediate patient acceptance – which is higher even than patients' rate of acceptance of pharmaceutical treatment. As established in Chapter 2, when physicians frame recommendations for behavior change as interventions to address a current health problem, patients overwhelmingly accept the advice and engage with the project of promoting behavior change. Importantly, this is distinct from citing the health risks of not complying with advice. We see in Chapter 2 that citing health risks can be done regardless of whether the recommendation is built on the basis of current illness management. Specifically, *this* practice is about couching the basis of the advice in improving a current health condition.

Patients display a positive orientation towards this form of lifestyle advice, whether it is done with a positive framing (e.g., *exercise will definitely help your blood pressure, I'd recommend it*), with a negative framing (e.g., *starchy foods will cause your triglyceride levels to increase, so stay away from those*). Notably, patients rarely resist this advice on the basis of prior knowledge, even when the link between health behavior and health outcome is relatively obvious. Patients also do not show resistance to the activity of *advising* when it is framed as illness management, so physicians can be confident explicitly *recommending behavior change*, as opposed to, for example, negatively assessing patient behavior and thereby implicitly endorsing behavior change. Physicians already frame lifestyle advice as treatment-relevant about 50% of the time, so we already know that this interactional practice can be easily implemented in this context.

Chapter 4 indicates that *how* a physician initiates a discussion of health behaviors will shape the patient's disclosure and subsequent description of lifestyle. While we might have anticipated patients would show a preference for reporting problematic health behaviors following routine history-taking questions (e.g., *do you smoke*), patients actually display more hesitancy to disclose here and provide more qualified and less detailed information about their health behaviors. However, the context of discussing problematic test results is treated by patients as uniquely fitted to discussing lifestyle. Following one-third of reports of problematic test results, patients *initiate* disclosures and conversations about their health behaviors. This indicates that the context of *reporting problematic test results* serves more than just the function of *informing*, but also provides a unique interactional opportunity for the discussion of lifestyle in the clinical encounter. This provides additional rationale for ensuring these conversations are initiated during the primary care encounter regardless of whether the results are also communicated online.

Following reports of problematic test results, physicians can either frame patients' past behavior as a potential contributing factor by soliciting information about their past behavior, or they can orient only to future behavior as relevant by moving straight to establishing a treatment plan. Both approaches have their advantages and disadvantages, which physicians can be taught to recognize. If a physician takes the forward-looking approach and immediately moves to establishing a treatment plan, the patient will likely immediately accept the plan and then move forward. Physicians can use this insight to promote forward progressivity of the consultation when necessary. When physicians take a backward-looking approach and request information about the patient's past health behaviors in this context, patients are very receptive. In this context, physicians can be confident requesting information about the patient's health behavior, as well as advising behavior change following patient disclosure. This approach encourages patient-initiated descriptions of the circumstances surrounding their behavior. Physicians can use this insight to promote patient involvement in behavior-change projects.

While promoting health behavior change is often a central goal for physicians treating patients with chronic illness, these goals must be balanced with concerns about time limitations in the consultation. Chapter 2 and Chapter 3 demonstrate the extent to which patient *resistance* to discussions of behavior change can halt the progressivity of the consultation. Physicians rarely initiate closing of the sequence at the first sign of patient resistance to lifestyle counseling. Rather, when patients display resistance to lifestyle advice, physicians spend considerable time pursuing patient buy-in. These sequences not only halt progressivity, but are not productive in the sense that physicians rarely secure non-minimal patient engagement in these lifestyle discussions. However, when physicians encounter patient resistance and then *alter* their approach to provide treatment-relevant advice, they secure patient acceptance of advice relatively quickly. Moreover, if they *start*

with treatment-relevant advice, patients systematically respond with immediate acceptance *in the very next turn*. Once a patient has accepted a physician's lifestyle advice, the physician can initiate expansion or easily close down the sequence. It is interactionally much easier for a physician to initiate a topic shift *after* a patient accepts the lifestyle advice. As such, these findings could be used to promote more positive conversations about lifestyle that the physician has more control over with regards to the amount of time being spent on the subject.

Similar to concerns surrounding the reality of *time limitations* in clinical care, we can also acknowledge concerns surrounding *variation between clinical practices* servicing low- and high-income communities. How do the findings in this dissertation speak to clinicians and health systems that work with high- versus low-income communities? First, we can acknowledge that physicians are more likely to expect and presuppose problematic health behaviors when initiating discussions of lifestyle in low-income clinics, and that patients disclose their problematic behavior in a way that is more defensive and projects a positive self-presentation. Realistically, we may not be able to train physicians to avoid encoding these presuppositions or expectations into every question about patient health behavior. However, the systematic differences we observe across institutions do underscore the importance of funding interventions that would reduce stratification in our healthcare systems and communities more generally.

To this point, there was one physician in these data who had relocated from Lowry to Hinsdale about five years prior, when she joined a larger healthcare system in Hinsdale. Many of his established patients followed, and she also acquired some new patients in Hinsdale. For the purposes of coding these data, this office was identified as a Hinsdale office, as this is where the doctor was located at the time of the recording. However, this primary care office provides an interesting case study when examined independently. Physician practices (presupposition,

optimization) and patient practices (upgrading, activity) followed the patterns observed in Highland/Hinsdale, as opposed to those observed in Lowell/Lowry. This is only one case, and would require a larger sample of relocated physicians make any larger claim, but this observation provides foothold indicating the important role the stratification of our healthcare system plays in these micro-level disparities.

Finally, I would like to emphasize that this dissertation provides a strong framework with which to design experimental research with the aims of developing targeted, communications-based interventions to promote behavior change. As outlined above, one example would be comparing a control group with an intervention group in which the physician was trained to frame any lifestyle advice as an intervention to address a health condition, then following up with patients to measure rates of behavior change. Developing interventions through this two-step inductive-experimental research process could benefit a variety of institutions in the United States, particularly managed care consortiums. This two-step approach has been adopted in the development of communications-based interventions in the United Kingdom, for example on the subject of improving physician communication with frequently-attending patients (Barnes et al 2018; Barnes et al 2019). Moreover, such findings can then be used to develop brief online communications training programs for physicians, greatly expanding the potential impact of these communications-based interventions (Parry et al 2013). While considerable resources have been provided for research on the *impacts* of lifestyle on chronic illness, there is little attention paid to how physicians actually *discuss* lifestyle with patients. This study not only highlights the important role communication plays in patient uptake of lifestyle advice, but it also provides a framework for developing grounded communications-based interventions which could then be distributed and instituted at very low cost.

5.3 Study Limitations

The sample of healthcare centers used in this study were collected from a single, large urban county in the Western United States. The sample is therefore not representative of clinics across the United States, particularly those in rural areas. I also did not collect data from free public clinics, private charity clinics, or on the other end of the economic spectrum, concierge practices. As such, these data do not represent the full spectrum of low- and high-income communities served in the United States. Seven of twelve physicians were recruited via snowball sampling methods, which introduces bias into the sample. The study relies on a cross-section of clinical consultations and no longitudinal data, so I was not able to analyze variation in patient responses to physician practices *within the same* physician-patient pair. The study is also limited by an absence of patient follow-up interviews, so patient behavior change following physicians' lifestyle advice was not measured.

5.4 Future Directions

Uncovering considerable variation in how patients respond to discussions of lifestyle based on physician framing, this dissertation shows that there is still important work to be done on the social reality of wellness, nonadherence, and the intersections of lifestyle and clinical care. This work has the potential to have a very positive impact on sociological research design, theoretical approaches to wellness and adherence, and on clinical interventions to address health disparities and health behaviors. This research area will only become more relevant as Medicare funding is further stretched, as promoting lifestyle change is so central to providing care for older adults and those with multiple chronic conditions.

Future conversation analytic studies in this area would benefit from collecting data in clinical practices that service a wider variety of patient populations. Because the negative health

consequences of lack of exercise, diet and smoking have the greatest impact on low-income communities and older generations, this area of research would benefit from the collection of data in free clinics as well as offices that primarily service Medicare patients. More specifically, the findings presented in this chapter indicate that it is important to continue to explore how patients respond to wellness versus treatment frameworks when discussing lifestyle more broadly in the clinical encounter – for example, during conversations where the patient may frame their behavior as non-problematic. This dissertation also highlights the important role conversation analysis can play in theoretical and methodological debates spanning sociology, psychology, public health, behavioral health, and healthcare management. I believe it is important that future conversation analytic research in this area continue to work to bridge these divides across disciplines.

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