Chapter 24

'Occasional' Drinking

Some Uses of a Non-standard Temporal Metric in Primary Care Assessment of Alcohol Use

Timothy Halkowski
University at Albany—SUNY

Introduction

> "Time is seemingly tamed if we treat it spatially on a calendar or the face of a clock, where we can make it appear as divided into separate units next to each other. But this also falsifies time. Real time has no divisions at all, but is uninterruptedly continuous: at midnight yesterday did not click over into today. . . . We have no experience of today being next to yesterday, as it is represented on a calendar. Reduced to space, time seems more under control—but only seems to be. . . . (This is not to deny that spatial reductionism is immeasurably useful & technologically necessary, but only to say that its accomplishments are intellectually limited, and can be deceiving)," (Walter Ong, *Orality & Literacy*, pgs. 75–76).

In primary care visits, doctors regularly ask patients if they use tobacco or alcohol. If the patient 'answers yes' to either question, the doctor regularly initiates a 'habit assessment' series, wherein questions as to amount, regularity of use, and possible interest in quitting are asked.[1] When physicians inquire about and assess a patient's alcohol or tobacco use, they regularly work to elicit a quantification of the patient's use. Specifically, doctors work to elicit *rates of use* from patients.[2]

Patients sometimes resist physicians' efforts to generate a rate of their alcohol or tobacco use.[3] One way they do so is by using non-standard temporal metrics to describe their tobacco or alcohol use (formulations such as 'sometimes,' 'once in a while,' & 'occasionally'). In this paper we will focus on patients' formulations of their use as 'occasional' as a method for obviating the quantification of their usage. That this formulation of use is specifically designed to obviate a 'rate of use' is something we will see both patients and doctors orienting to.

In studying this work by patients, we will be analyzing an interactional move that has general relevance to interaction between representatives of institutions and their publics (*e.g.*, patients, clients, customers, *etc.*). As one of the primary actions of institutional representatives is the collection of information and data from others, it is likely that there are methods that people occasionally use to resist such processing.[4]

This study also has broader relevance to what has been termed the 'morality of cognition' (Heritage 1984; Garfinkel 1967; Drew 1998; Lynch 1991, 2006). When we consider how patients and doctors interactively manage how to describe and assess a patient's use of alcohol or tobacco, we see that patients can contest these descriptions. In essence, these contests are about how one ought to appropriately, fairly, accountably describe and assess this patient's usage. While (in theory) any patient's usage can be mathematically formulated as a 'rate of use,' patients sometimes treat those formulations as inappropriate, or in some fundamental way incorrect. Indeed, sometimes physicians agree with the patient's rejection of a rate. It is at just this point that we can see how abstract quantitative mathematical formulations of use are treated as inappropriate for the assessment of some patients' alcohol use, and non-standard temporal metrics of use are treated as adequate and accountably correct descriptions.

The data for this study are drawn from a corpus of 100 audio & video taped primary care visits, collected from five clinics (one from the southeastern U.S., four from the midwest U.S.). The data were transcribed using the Jefferson transcription system (Atkinson & Heritage, 1984).

Unpublished manuscript. (2007). Reprinted with permission.

Background

In this chapter I mean to highlight a key aspect of physician—patient discussions regarding alcohol use.[5] The work doctors do in these series of questions generates a formulation of the patient's alcohol or tobacco use that can be termed 'regimented' ('to put into systematic order, to subject to uniformity and rigid order').[6] The 'regimenting' of some information, (such as a patient's substance use) is a scientific technique that has its own history, one nicely described by the historian Theodore Porter.

> "Any domain of quantified knowledge, like any domain of experimental knowledge, is in a sense artificial. But reality is constructed from artifice. By now, a vast array of quantitative methods is available to scientists . . . Once put in place, they permit reasoning to become more uniform, and in this sense more rigorous," (1996:5).

A key part of the generation of uniformity in information is the use of shared, specifiable metrics or measures (Crosby, 1997). Once a patient's usage is rendered in a standard, abstract, and uniform manner, it is comparable to other cases, and it is possible to assimilate it into a population of like measures. Given the centrality of this regimentation to institutional work, analyses of interactions wherein quantities and rates are elicited and generated are important contributions to the broader historical literature on the development and spread of quantification in western society (Clanchy 1993, Crosby 1997, Porter 1996).

Harold Garfinkel did some of the most insightful early work on the interactional generation of 'counts.' In an early unpublished manuscript he highlighted ways that members' work of counting members is built upon local relevancies that are not reducible to abstract mathematical formulation (1962). In any effort to quantify, there are judgment calls regarding what should count and what should not (cf. Lynch 1992, 2006, Halkowski 2006b). Sacks' lectures as well are filled with similar observations regarding "members' methods of measurement" (1988/89, 1992).

More recent work (Pomerantz 1986, Button 1990, Maynard et al., 2001, Drew 2003, Boyd & Heritage 2006, Stivers & Heritage 2001), has highlighted ways that precision and approximate measures are crucial (and morally laden) resources in interaction. In addition, this recent research has underscored ways in which the interactional generation of measures is a fundamental activity of institutional interactions.

Central to the work of most people-processing institutions, and many of their employees, is the elicitation of information from others, so as to generate rates (Zimmerman 1971, Maynard et al. 2001; Drew & Heritage 1992, Beach & Mandelbaum 2005, Heritage & Maynard 2006). The work doctors do to elicit and generate counts and rates of alcohol and tobacco use (and patients' work to sometimes resist this) is a crucial realm for researchers to investigate. The centrality of this institutional work, and the ways it can become contentious for agency and individual, make it a perspicuous site for the investigation of social order's generation and maintenance.

Analysis: Orders of Regimentation In Discussions Of Alcohol Use

Consider the following data segment:

Data excerpt 1 [ssmc3–3.5]

1	Dr:	'kay, ahhh do you drink?
2		(.6)
3	Pt:	Mm hmm.
4		(.4)
5		(ta-) Beers.
6		(.8)
7		That's it.
8	Dr:	[How much.]
9	Pt:	[Beer is] my favrite.
10		(.6)
11	Dr:	How mu[ch would you sa:y.]
12	Pt:	[About ah ca::n.]
13		(.6)
14	Dr:	Everyday, ahh
15		(1.0)

16 Pt: Not (.) everyday. (.) A sixpack 'al last me two
17 weeks just about.
18 Dr: °Okay.°

In doctor-patient discussions of alcohol and tobacco use there are two levels of 'regimenting' that we should note. At the start of such discussions, there is an initial question as to whether or not the patient uses alcohol or tobacco. This question is frequently formulated as a 'yes/no interrogative' (Raymond, 2003), as in the above data segment. Such questions are designed to 'prefer' a yes or no answer, and in this case the patient offers an affirmative response (line 3). She expands her answer by offering the type of alcohol she drinks (line 5), asserting the exclusivity of her preference (line 7), and accounting for the exclusivity of her preference (line 9). In these assessment series, patients' affirmations of use are routinely followed by doctors' inquiries as to amount, rate, and history of use (as we see here in lines 11 & 14).

But while patients can offer simple 'free-standing' 'type conforming' answers to this question ('yes' or 'no') such answers are actually uncommon. Instead, right at the outset of this line of inquiry patients can contest what *ought* to count as 'smoking' or 'drinking,' thus resisting this first level of regimentation (Halkowski, 2006b).

Once it is established that a patient 'drinks' or uses tobacco, a second order or level of regimentation occurs, whereby the doctor works to elicit a *rate of use* (as in the above data segment, lines 11–18). In the above data segment, the doctor works to elicit a rate of use by offering a candidate rate of use for the patient to confirm, alter or reject ('everyday,' line 14). This kind of temporal metric ('everyday') is a key resource in the quantification and 'regimentation' of patients' habits because it is a standardized or regularized temporal metric (as are metrics such as 'every week,' 'every month,' etc.). What they have in common is a standard temporal term, joined with the modifier that highlights the systematic regularity, or periodicity of the event.[7]

While patients can respond to such inquiries with straightforward rates (e.g., 'a pack a week,' 'a six-pack or two a week'), they can also work to resist this work by the doctor. Fundamentally, the stance some patients take is that while they drink/smoke, it's not at a level that should be considered troubling or medically relevant.[8]

In the following data segments, we will be working to understand how patients use the non-standard temporal metric of 'occasional' alcohol use to resist the doctors' work of formulating one's drinking practices into an abstract regularized rate.

Analysis: 'Occasional' Drinking

Data excerpt #2 [IM/DL/211103]

1 Dr: Do you ahmm (1.2) do you smoke, (0.2)
2 Pt: Mm hmm (0.2)
3 Dr: How many packs a da:y
4 (0.4)
5 Pt: a pack of cigarettes lasts me two days.
6 (1.4)
7 Dr: okay and ah- how many years have you done that.
8 (0.5)
9 Pt: sinc:e eighteen.
10 (1.4)
11 Dr: °kay° alcohol,
12 (0.5)
13 Pt: Alcohol I'll drink occasionally.
14 (0.4)
15 like birthdays:: [(.) Thanksgiving]
16 Dr: [2 head nods]
17 Pt: (.h) Christmas
18 (0.5)
19 Pt: [well (new year's)
20 Dr: [so not every weekend
21 Pt: n:o (0.5) n:o (0.3) n:o.
22 ((shaking head no)).
23 (1.7)
24 Dr: and at one sitting how much would you have.

In line 11 the doctor acknowledges the patient's response to the prior question (regarding his history of tobacco use), and then asks the patient if he uses alcohol. This question is built upon its sequential location, following the doctor's earlier question on tobacco use (line 1).

After a delay that presages a dispreferred response,[9] the patient offers a non-type conforming response (Raymond 2003), characterizing his drinking as 'occasional.' The patient initially lets this turn component stand as possibly complete, but then expands his answer turn by offering two instances of drinking occasions (line 15). In overlap with 'thanksgiving,' the doctor gives two quick head nods, acknowledging the answer expansion and encouraging the patient to continue. The patient further expands his answer (line 17) by offering another holiday that may be an occasion for his use of alcohol, and then, after a brief silence, he adds 'new year's.' He marks it via his introductory 'well,' treating this as one that perforce includes alcohol use, and therefore *must* be mentioned in this calendrical sequence of alcohol-use occasions.[10]

In overlap with the patient's addition of 'new year's' to his list of drinking occasions, the doctor inquires 'so not every weekend' (line 20). This turn (introduced via an upshot marker) serves as a confirmation elicitor, asking the patient to confirm that 'every weekend' would not be an accurate way to characterize his drinking. The upshot marker and negation serve to contrast this formulation with the patient's prior characterization of his alcohol use.

Note that the doctor uses a particular temporal formulation in this confirmation elicitor: 'every weekend.' He thereby treats 'weekend' as a temporal formulation related to the use of alcohol. His use of 'every' serves to highlight periodicity and regularity of use, as contrasted with the patient's own formulation of his drinking as sporadic or irregular. This contrast (between regularized patterns of use, and sporadic occasions of use) is one that both patients and doctors treat as relevant to alcohol use assessments. Note this well, as it will be a feature of each of these sequences.

Data excerpt #3 [IMdre181103]

1	Dr:	Do you smoke at all,
2	Pt:	No.
3	Dr:	'Okay.' any alcohol,
4	Pt:	('hhh) ahhm only occasional
5	Dr:	Like the holidays
6	Pt:	Right.
7	Dr:	Not on the weekend or anything.
8	Pt:	No.

In the above data segment, the initial question regarding alcohol use is built sequentially off of the doctor's earlier question regarding smoking (cf. data segment #2, line 11, above). To this yes/no question, the patient responds with a non-type conforming answer: a minimizer plus 'occasional' (line 4). By this response, the patient is marking that his alcohol use can't be accurately or appropriately characterized by answering yes. The doctor responds by offering a candidate 'type' of occasion for drinking for the patient to confirm or elaborate upon (line 5). The patient readily confirms that candidate occasion-type (line 6). Following this, the doctor in line 7 offers a contrasting candidate formulation of alcohol use periodicity ('not on the weekend or anything').

This contrasting candidate formulation of alcohol is similar to the one in data segment 2, line 20 above. The same standardized temporal metric unit ('weekend') is offered, and that metric is presented as a regularized, recurring time for alcohol use ('every weekend,' 'the weekend'). So in both cases that we have considered, the doctor responds to the patient's activity-formulation of 'occasional' drinking by eliciting an explicit rejection of a contrasting candidate alcohol use formulation—one that highlights a regularized pattern of drinking.

Data excerpt #4 [Im/abd/hx2]

1	Dr:	Do you do you drink alcohol,
2	Pt:	No:
3		(.)
4		Occasiona[lly (just not ah)]
5	Dr:	[occasionally]
6		okay.
7		(0.5)
8	Dr:	How might you drink occasionally
9	Pt:	Ahh:m parties (.) like (.) birthday parties
10	Dr:	[mm hmm]

11 Pt: [(so) its] not a everyday its not a a:ll day
12 Dr: mm hmm, (0.4)
13 Pt: ahhm (2.0) °I don't like it
14 Dr: [(yeah)(okay)]
15 Pt: [I'm (well)] I just do it°
16 (0.7)
17 Dr: °mm hmm°
18 Pt: Its not a habit [(or anything like] that)
19 Dr: [(okay okay)]
20 Dr: ((asks about street drug use))

In line 1 the doctor (employing the yes/no interrogative) asks the patient if she uses alcohol. Here the patient responds initially with a 'type conforming' response ('no') (Raymond 2003). After a brief silence, the patient expands her answer turn by adding the component 'occasionally just not ah' (line 4). Via this answer expansion, the patient qualifies her initial 'no' answer, and shades it into a more nuanced formulation, one that also 'breaks the mold' of the initial 'yes/no' question (Stivers & Heritage 2001, Raymond 2003), and thereby resists formulation by the binary template: drinker/nondrinker.

In lines 5–6 the doctor acknowledges the patient's shifted formulation of her alcohol use. He then elicits explication of her self-formulation of occasional drinking (line 8). To this the patient responds with candidate drinking-occasion ('parties'), and after a micro-pause, modifies that instance with the category 'birthday,' thus highlighting the relatively benign and limited set of occasions she is invoking via 'party' occasions (line 9).[11]

The doctor acknowledges this elaboration (line 10), and in overlap the patient expands upon her initial explication of drinking occasions (line 11). She introduces this expansion via an upshot marker ('so') thus casting the utterance to come as a characterization or reformulation of her drinking behavior. She then produces two negatively formed characterizations of her alcohol use: 'its not a everyday its not a all day' (line 11).[12] It is by now a well worn observation that when speakers make a negative observation there is generally something special being done, in that in principle there are an infinite number of negative observations that can be made in any setting (Sacks 1992a, 1992b). By characterizing her alcohol use as 'not everyday,' the patient is making explicit that her use is not regularized and frequent. By stating that her drinking is 'not all day' she is further highlighting that individual 'sittings' or drinking events are not prolonged. Via her invocation of these two negative contrastive formulations, the patient is treating these characterizations (regarding periodicity and duration) as generically relevant in the assessments of alcohol use.

We can now look back to line 4, where the patient expanded her initial 'no' answer into 'occasionally just not ah.' We can now see some possible formulations she headed towards, before abandoning the utterance. These expansions in line 11 can be heard as retrieving and completing that initial fragment.

In line 12 the doctor acknowledges the patient's negations, and the patient goes on to add that she doesn't like drinking, but simply does it (lines 13 & 15).[13] In line 18 the patient further expands her answer, offering yet another negatively framed characterization of her alcohol use ('its not a habit or anything like that'). Here she explicitly addresses the potentially habitual nature of drinking, and denies the applicability of that description (or 'anything like' it) to her, to which the doctor responds in overlap with repeated acknowledgement tokens (line 19).

Via her three negatively formulated characterizations, the patient displays the potential relevance of the periodicity, duration, and habitual nature of one's alcohol use. These are each explicit ways to support one's own stance as an 'occasional' user of alcohol.

Data excerpt #5—[SSMCPC22]

1 Dr. How 'bout (.) have you been ah drinker in the past
2 or [don't] you drink very much at all.
3 Pt. [No.]
4 Dr. Okay.
5 Pt. Maybe an occasional wine at ah wedding or somethin
6 I don't even do that anymore.
7 Dr. Uh huh,
8 Pt. Never smoke never drank.
9 Dr. Does- (.) do anythings run in the family in
10 particular? (.) Like- that your parents died of?

In this data excerpt, the doctor asks the initial alcohol use question in a different and rather more complex manner than in the previous examples. In lines 1 the doctor initially asks if the patient has 'been ah drinker in the past.' Where all the other data excerpts show doctors asking about the activity of drinking, here the doctor is asking the patient if she was categorizable (in the past) as a 'drinker.'[14] Note that just as the doctor starts to extend and reformulate his question, the patient strongly, with no mitigation and almost no delay, answers the yes/no interrogative with a type-conforming 'no' (line 3).

Just as she does this, the doctor works to offer an alternate characterization for the patient to confirm or reject, this one focused on her current behavior (line 2). Following the doctor's acknowledgement of her answer (line 4), the patient offers an answer expansion (lines 5–6). She opens this expansion with a possibility marker ('maybe') highlighting that she may have had 'an occasional wine at a wedding or something.' By invoking a drinking occasion such as a wedding, the patient is highlighting that whatever drinking she may have done was likely quite sporadic, rather than regular and patterned.[15]

To claim 'an occasional wine' is to claim one drink. Her appended phrase 'or something' (line 5) stresses that it would only be at a 'wedding-type event' that she would be likely to have a glass of wine. The patient then concludes her answer expansion by asserting that she no longer 'even' consumes alcohol to that limited degree anymore. Note here her use of the term 'even,' whereby she is able to emphasize the ways in which her past alcohol use was quite limited.

In line 7 the doctor acknowledges this answer expansion by the patient. Then the patient characterizes her behavior thus: 'never smoke, never drank' (line 8).[16] Via this summarizing self-assessment, the patient asserts that what drinking she did in the past cannot reasonably be treated as medically relevant. In this light, her shifting answer to the doctor's initial question about drinking is rather useful for us as researchers. The progressive shifts in her answer expansions simultaneously demonstrate allegiance to the literal truth of the matter ('an occasional wine at a wedding or something'), as well as the situated, relevant answer for the purpose of this visit ('no . . . never smoke, never drank'). The patient, in this elaborated answer turn, can show the doctor that she can offer the literal answer, and at the same time strongly indicate what she takes to be the locally procedurally relevant answer. As it turns out, the doctor here does not contest either form of her answer.

Conclusion

> "What was clearly new, however, in the contribution of the work bell or the city bell used for purposes of work was that instead of a time linked to events, which made itself felt only episodically and sporadically, there arose a regular, normal time. Rather than the uncertain clerical hours of the church bells, there were the certain hours spoken of by the bourgeois of Aire. Time was no longer associated with cataclysms or festivals but rather with daily life, a sort of chronological net in which urban life was caught," (J. Le Goff, 1980:48).

Both the Ong quotation (at the start of this paper) and the Le Goff quotation above describe historical shifts in how time is culturally rendered, grasped, and managed. Both scholars highlight ways in which time has been 'rationalized' and standardized. Similarly, in this chapter we focused on two fundamentally different ways that time is used in the formulation of patients' alcohol use descriptions. Generally doctors work to elicit a standardized rate of use metric (e.g., 'six drinks per week'). But there is a fundamentally different temporal metric that patients can invoke: a non-standard temporal metric of use, such as 'occasional' drinking. Invoking this metric is a method whereby patients obviate a physicians' otherwise standard push to elicit a rate of use.

We have seen in this chapter that doctors and patients regularly contrast invocations of 'occasional' drinking with regularized, rate of use formulations of drinking, and treat the former as obviating the need to elicit or offer the latter. This analysis of the detailed interactional methods used by patients to claim to be 'occasional' consumers of alcohol advances lines of inquiry in several domains, to wit: the morality of cognition; the data collection practices of institutions; and the broad sweep of quantification in history.

i. The Morality of Cognition

Because every drinker's alcohol usage can (in principle) be mathematically formulated as a rate of use (a rate per some standard temporal unit, e.g., beers/week), it is an inherently interesting social phenomenon when someone's alcohol usage is not formulated that way (e.g., when doctors don't attempt to elicit a rate, or when patients obviate the effort to do so). As we have seen, patients and doctors can treat some patients' alcohol use as not requiring or fitting into a

rate of use description. Instead, they treat some types of use as accountably describable as 'occasional' (Garfinkel 1962, 1967; Heritage 1984, Hilbert 1992; Drew 1998; Lynch 1991, 2006).

Deeply connected to this point are the ways in which patients display themselves to be accurate, appropriate, accountable reporters of their behavior, including their alcohol use.[17] For example, we have noted that as patients claim to 'occasionally' drink, they take pains to offer those descriptions and characterizations in ways that highlight the minimal, non-regularized, episodic nature of their alcohol use. Recall here data excerpt #2, line 19, where the patient introduces his answer expansion of 'new year's' with 'well,' (highlighting this addition as an 'of course' occasion where alcohol almost by definition would be consumed), thereby displaying himself as a reliable reporter of his alcohol use.

[Data excerpt #2]

	13	Pt.	Alcohol I'll drink occasionally.
	14		(0.4)
	15		like birthdays:: [(.) Thanksgiving]
	16	Dr.	[2 head nods]
	17	Pt.	(.h) Christmas
	18		(0.5)
—>	19	Pt.	[well (new year's)
	20	Dr.	[so not every weekend

Similarly, recall data segment #4, line 9, where the patient amends 'parties' by giving as an instance 'birthday parties.'

[Data excerpt #4]

	8	Dr.	How might you drink occasionally
—>	9	Pt.	Ahh:m parties (.) like (.) birthday parties
	10	Dr.	[mm hmm]
	11	Pt.	[(so) its] not a everyday its not a a:ll day

By using this sort of example, the patient can underscore the *kind of event* where she would have a drink, and by implication, the *kind of drinker* she is. Thus, analyzing the specific features of patients' invocations of 'occasional' drinking has allowed us to discover details of how patients present themselves to doctors as reliable accountable reporters of their alcohol consumption.

ii. Data Collection Practices of Institutions

This chapter gives us a more detailed understanding of quantification as a generic practice, and especially as it is exhibited in interactions between institutions' agents and their publics. Contemporary bureaucratic institutions and their agents work to elicit abstract generalizable quantifications and rates from customers, clients, patients, inmates and others. Interactions wherein this kind of data is elicited are a central activity of institutions and their agents. Yet we have described in this chapter an interactional method ('invoke 'occasional' use') that obviates institutional (in this case medical institutional) pushes for objectively standardized measures and rates. Thus this analysis highlights a powerful way that interactional practices can shape the sort of data that institutions are able to collect (cf. Maynard et al., 2001).

For institutions, (and institutional interaction) it is helpful to have recourse to 'occasional' as a non-standard metric of use. In its own way, a non-standard metric like 'occasionally' can serve to preserve the rationality of quantitative rate of use measures. It can do this by allowing exceptions to the otherwise pervasive push for abstract, regular rates of use. To not allow for a class of exceptions would mean that doctors would have to relentlessly demand a rate of use formulation from *every* patient. (Recall, any alcohol use can (in principle) be formulated as a standardized rate). A relentless push for standardized rates of use could take a patient's two drinks at New Year's, two at Christmas, and perhaps six total at various birthday parties, and generate a rate of 0.192 drinks/week. While mathematically correct, neither patients nor doctors would treat this as a reasonable description of one's alcohol use. (Indeed, following Bloor (1978) such a rate might be termed an 'abomination.') Hence it is not surprising that we have interactional methods for 'exception-barring.' Allowing for the use of 'occasionally' is a way to deal with what otherwise might be exceptional 'monsters' for standardized quantification, thereby preserving the rationality of rate of use measures.

iii. Quantification as a Historical Process

The ability of patients to interactionally obviate doctors' push for a rate of use is a fascinating exception to a well-documented historical movement, whereby measures have increasingly been standardized, regularized, abstracted and thereby rendered comparable with other data from a population (Clanchy 1993; Crosby 1997, Porter 1996, Hilbert 1992).

The work of bureaucratic institutions for the last several centuries exemplifies this pervasive expansion of quantification (Porter 1996), and yet we have here described an interactional method that cuts against the grain of this rather strong geographically and historical dispersed phenomenon.

In this chapter I have attempted to explicate ways that doctors and patients use standardized and non-standardized temporal metrics. The institutional push for standardized 'rates of use' can be seen as a broader 'regimentation of the habitus' that occurs in medical interactions (Halkowski 2007). In numerous ways patients' habits and practices are interactionally rendered as standardized and comparable quantities (Halkowski, 2002, 2006b, 2007). The work doctors do to elicit and generate these counts and rates (and patients' work to sometimes resist this) is a crucial realm of practices for researchers to investigate. The centrality of these practices for institutions, and the ways they can become contentious for agency and individual, make them a perspicuous site for the investigation of social order's generation and maintenance.

Notes

1. 'Answers yes' here is a gloss for the numerous and sometimes quite subtle ways that patients affirm that they use tobacco or alcohol. See Halkowski (2006b) on other ways that patients respond to the questions 'do you smoke/drink?'

2. For an analysis of this work, see Halkowski, 2002.

3. See Halkowski 2007.

4. On the 'people processing' work of institutions, see Zimmerman (1971), Maynard (1984), Drew & Heritage 1992, Maynard *et al.*, 2001.

5. Similar analyses of doctor-patient discussions of tobacco use are in preparation. See Halkowski 2007.

6. *Oxford English Dictionary*.

7. This is not to suggest that such temporal terms are always treated as stable. In some cases temporal terms like 'day' can be 'decomposed' by the patient. (For example, one patient, responding to a doctor's question states "I work third shift, so *my* days are not *your* days").

8. Thus one patient, asked how much she smokes, responds, 'I'm not a heavy smoker, if that's what you're talking about.'

9. In primary care tobacco and alcohol assessment discussions, patients demonstrably treat some answers to 'do you smoke/drink?' as 'preferred,' by offering them with little or no delay, no mitigation, and no accounting. Indeed, when a patient can answer by saying not simply 'no,' but 'never,' they will do so (Halkowski, 2002).

10. It is by such subtle shadings as this introductory 'well' that patients demonstrate themselves to be accurate, appropriate, and accountable reporters of their behavior when speaking with their doctor. For more on how people show themselves to be 'good patients,' see Halkowski (2006).

11. Note the emphasis on the first syllable of 'birthday.' This can be a way of contrastively marking this type of party as distinct from other types of parties. Emphasizing 'birthday parties' can be a way for the patient to highlight that she is not a heavy 'partier,' but simply one who attends birthday parties. *I.e.*, these are not regular, frequent parties, but annual parties.

12. Compare this turn with the prior two data excerpts, wherein the physicians elicited just such a confirmation from their patients.

13. We can briefly note the contrast the patient offers between 'liking it' and 'doing it.' This contrast appears to assert that alcohol use has no special claim upon her, but is simply (or 'merely') a practice. Of course, any claim that something is 'simply' 'x' is itself interactionally delicate or problematic, in ways that Sacks (1992a) and Garfinkel & Sacks (1970) have demonstrated.

14. Note that the patient is expected to hear 'drinker' as referring to the consumption of alcohol. This is one way that the patient is seeable as orienting to this as a medical encounter.

15. By invoking weddings as the sort of events wherein she would 'have an occasional wine,' the patient is almost literally claiming to be a 'ceremonial' drinker, i.e., one who only by sense of communal obligation raises a glass for the wedding toast.

16. Earlier in the discussion the patient was asked if she was 'a smoker, or a past smoker,' to which she responded, 'never.'

17. This is part of the way people do: 'being a good patient.' Cf. Sacks 1992, Halkowski 2006.

References

Ackroyd, P. 2001. *The Collection*. London: Chatto & Windus.
Atkinson, J. M. & J. Heritage, 1984. *Structures of Social Action*. Cambridge: Cambridge University Press.

Beach, WA & Mandelbaum, J. (2005). "My mom had a stroke": Understanding how patients raise and providers respond to psychosocial concerns. In LH Harter, PM Japp, & CM Beck (Eds), *Narratives, health, and healing: Communication theory research*. Lawrence Erlbaum Associates.

Bloor, D. 1978. Polyhedra and the abominations of Leviticus. *British Journal for the History of Science 11*: 243–72.

Boyd, E. & J. Heritage. 2006. Taking the patient's medical history: Questioning during comprehensive history taking In J. Heritage and D. Maynard (eds.), *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press.

Button, G. 1990. On members' time. In B. Conein, et al., (eds.), *Les formes de la conversation, Vol. 1*, Paris: CNET, pgs. 161–82.

Clanchy, M. 1993. *From memory to written record: England 1066–1307*. London: Blackwell Publishers.

Crosby, Alfred. 1997. *The measure of reality: Quantification in Western Europe, 1250–1600*. Cambridge: Cambridge University Press.

Drew, P. 1998. Complaints about Transgressions and Misconduct. *Research on Language and Social Interaction*, v31 n3-4, pgs. 295-325.

———. 2003. Precision and Exaggeration in Interaction. *American Sociological Review*, Volume 68, Number 6, pp. 917–938.

Drew, P & J. Heritage, (eds.) 1992. *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.

Garfinkel, H. 1962. Thoughts on how members count members. Unpublished ms.

———. 1967 [1984]. *Studies in Ethnomethodology*. Cambridge: Polity Press.

Garfinkel, H., & H. Sacks, 1970. 'On formal structures of practical action.' In: J.C. McKinney & E.A. Tiryakian, (eds.), *Theoretical sociology: perspectives and developments*. New York: Appleton-Century-Crofts: 338–66.

Halkowski, T. 1990. "Role" as an Interactional Device. *Social Problems*, Vol. 37, No. 4, pgs. 564–577.

———. 2002. 'Making Rates: Physician and Patient uses of temporal metrics in characterizing alcohol consumption.' Presented at the annual meeting of the American Sociological Association (ASA), in Chicago, IL, August 2002.

———. 2006. Realizing the Illness: Narratives of symptom discovery. In J. Heritage & D. Maynard (eds.) *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press.

———. 2006b. What counts as smoking/drinking?: Patients' orientation to medical relevance. Unpublished ms., presented at the annual meeting of the American Sociological Association, in Montreal, Canada, August 2006.

———. 2007. Resisting Counts/Accounting for Resistance: Interactional methods for avoiding quantification of one's habits. Presented at the International Communication Association conference, San Francisco, CA, May 24–28, 2007.

Heritage, J. 1984. *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.

Heritage, J. & D. Maynard (eds.). 2006. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press.

Hilbert, R. 1992. The Classical Roots of Ethnomethodology. University of North Carolina Press.

Le Goff, J. 1980. *Time, work and culture in the middle ages*, Chicago: University Of Chicago Press.

Lynch, M., 1991. 'Method: measurement ordinary and scientific measurement as ethnomethodological phenomena,' pgs. 77–108, in G. Button, (ed.) Ethnomethodology and the human sciences. Cambridge: Cambridge University Press.

———. 2006. Cognitive activities without cognition? Ethnomethodological investigations of selected 'cognitive' topics, *Discourse Studies*, Vol. 8, No. 1, pgs. 95–104.

Maynard, D. 1984. *Inside Plea Bargaining: The Language of Negotiation*. New York: Plenum Press.

Maynard, D, H. Houtkoop-Steenstra, N. Cate Schaeffer, & J. van der Zouwen (eds.) 2001. *Standardization and Tacit Knowledge: Interaction and Practice in the Survey Interview*, New York: Wiley Press.

Ong, W. 2002. *Orality and Literacy*. London: Routledge.

Pomerantz, A. (1986). Extreme case formulations: A way of legitimizing claims. *Human Studies*, 9, 219–229.

Porter, T. 1996. *Trust in numbers: The pursuit of objectivity in science and public life*. Princeton University Press: Princeton, NJ.

Raymond, G. 2003. Grammar and Social Organization: Yes/No Interrogatives and the Structure of Responding. *American Sociological Review*, Vol. 68, No. 6. (Dec., 2003), pp. 939-967.

Sacks, H. 1988/89. On members' measurement systems. *Research on language in social interaction*, vol. 22, pgs. 45–60.

———. 1992. *Lectures on conversation* (Vols. 1 & 2). Oxford, England: Blackwell.

Stivers, T. & J. Heritage. 2001. Breaking the sequential mold: Answering "more than the question" during medical history taking. *Text*, 21 (1/2): 151–185.

Zimmerman, D. 1971. "The practicalities of rule use," pgs. 221–238 in J. Douglas (ed.), *Understanding Everyday Life*, Chicago: Aldine Press.

Handbook of Patient-Provider Interactions

Raising and Responding to Concerns About Life, Illness, and Disease

Edited by

Wayne A. Beach

San Diego State University

HAMPTON PRESS, INC.
NEW YORK, NEW YORK

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Handbook of patient-provider interactions : raising and responding to concerns about life, illness, and disease / edited by Wayne A. Beach.
p. ; cm. — (Health communication)
Includes bibliographical references and index.
ISBN 978-1-57273-692-4 (hardbound) — ISBN 978-1-57273-693-1 (paperbound)
I. Beach, Wayne A. II. Series: Health communication (New York, NY)
[DNLM: 1. Physician-Patient Relations. 2. Attitude of Health Personnel. 3. Communication. 4. Medical History Taking. W 62]

2012023889

610.69'6—dc23

Cover design by Wendy Shapiro
Cover photos from iStockphoto. Used with permission

Hampton Press, Inc.
307 Seventh Ave.
New York, NY 10001