Chapter 7

Negotiating the Legitimacy of Medical Problems

A Multiphase Concern for Patients and Physicians

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In this chapter, I explore a theme that often emerges in the context of patient problem presentation, but that also surfaces elsewhere in the medical visit. This is the theme of legitimacy: Specifically, the idea that the patient's visit to seek medical care should be properly motivated by an appropriate medical problem. From the physician's perspective, this theme is summed up in a rather hard-nosed fashion by the New Zealand primary care physician who observed that "In order to have the privilege of talking to your doctor, you must fulfil the essential precondition of being sick. Then you may go to him and ask him if he will perform his professional services upon you" (Byrne & Long, 1976, p. 20). At the societal level, this theme is enshrined in everyday language that contains numerous terms for patients who inappropriately seek medical care: hypochondriac, malingerer, crock and so on, and the pathological disposition to do so (as manifested in Munchausen's Syndrome) is itself treated as a medical condition. And it is also present in contemporary popular culture. A recent cartoon in the *New Yorker* magazine depicts a nurse entering a crowded waiting room and saying, "We're running a little behind, so I'd like each of you to ask yourself 'Am I really that sick, or would I just be wasting the doctor's valuable time.'" (*New Yorker*, May 14, 2001). And this concern helps to explain the peculiar conflict we sometimes experience when we go to the doctor: we want to be told that we are well, but we also would like to have had 'good reasons' for wrongly believing that we were not. As another *New Yorker* cartoon, depicting the delivery of a diagnosis, caricatures the concern: "You're not ill yet, Mr. Blendell, but you've got potential" (*New Yorker*, September 11, 1998).

These common sense normative orientations have been systematized by social scientists. In his classic formulation of the "sick role," Parsons (1951, p. 436–439) observed that persons entering the sick role are entitled to some exemption from normal social tasks but that, correspondingly, they have the obligation to view being sick as undesirable and to resist any temptation to take advantage of the "secondary gains" of the sick role in the form of economic, social and emotional support. It is this latter set of obligations, of course, that inform the morally loaded terminology and orientations sketched above.

By the very act of making the appointment and walking into the physician's

office, patients commit themselves to two interrelated premises. They assert (a) the existence of a concern or problem that they lack the knowledge, skill or other forms of expertise to manage on their own, and (b) project the concern or problem as one that is properly handled through the exercise of medical expertise. Given this commitment, a significant part of the patient's project during the visit can concern the justification of the visit itself. In providing for their decision to seek medical assistance, patients may find themselves designing their descriptions of events, experiences and circumstances so as to communicate "good reasons" that will justify them being in the physician's office.

Thus, from the outset of the medical visit, patients can face a *doctorability_issue*. For patients, a doctorable problem is one that is "worthy of medical attention, worthy of evaluation as a potentially significant medical condition, and worthy of advice and, where necessary, medical treatment" (Heritage & Robinson, 2006, p. 58). Establishing that they have a doctorable problem is a method of justifying the decision to visit a physician. It is a means for patients to show that they are reasonable people, which in this context means showing that they have a problem or a concern for which seeking medical assistance is a reasonable solution. The presentation of a complaint determined to be nondoctorable can deprive the patient of authoritative medical support for their claim to financial and other benefits from entering the "sick role" (Freidson, 1970; Parsons, 1951, 1975), and engender a vulnerability to the judgment that they were misguided in seeking medical assistance, are over-concerned about their own or their children's health, or in illegitimate search of "secondary gains" from the sick role itself. Patients' concerns with doctorability thus center on showing that they are reasonable people, with "good reasons" to present themselves at the doctor's office. Providing for that reasonableness effectively converges with providing for the doctorability of the concern that they present.

Although patients may vary in the extent to which they feel obligated to legitimate a medical visit, and, of course, many conditions—for example, accidental injuries—scarcely require elaborate justification, patients who present with the normal run of primary care complaints frequently manifest a concern with the legitimation of the visit. In the remainder of this chapter, I will illustrate the emergence of this issue in the context of (a) problem presentation, (b) (verbal) history taking and physical examination, and (c) the diagnosis and counseling phase of the medical visit. My objective is to show that the problem of legitimacy is indeed a multiphase concern.

Problem Presentation

Let me illustrate this claim with a case in which the patient's concern with the doctorability of her problem is unmistakable. This patient has previously been treated for a small basal cell carcinoma on the back of her neck, and she has recently discovered a suspicious raised spot (or "mole" (line 7)) at, or close to, to the place where she was previously treated. If this discovery repre-

sents a recurrence of the earlier condition, the patient's situation may be quite dangerous:

(1) [Heritage and Robinson, 2006]
1 Pat: (I'm here on fal[se pre- pretenses.)<I think.
2 Doc: [ˑhh
3 Doc: [<Yes.
4 Pat: [ehh! hih heh heh heh!
5 ((Five lines omitted))
6 Pat: I asked my husband yesterday 'cause I could feel: (0.8) (cause)
7 I: could feel this li'l mo:le coming. An:d: uh (0.5) (he) (.) I:
8 hh thought I better letchya know-<uh well I asked my husband 'f
9 it was in the same place you took off thuh (0.5) °thee (mm)
10 thee:°([ )
11 Doc: [That's why you've come in be[cause of the mo:le.
12 Pat: [that's why I ca:me, but=
13 Doc: =H[ow long 'as it been-]
14 Pat: [t h i s m o r ning-] I: I didn' I hadn't looked yesterday
15 he said it was in the same place but ˑhh but I: can feel it
16 nah- it's down here an' the other one was up here so I don't
17 think it's: th'same one at a:ll.
18 Doc: Since when.
19 (0.8)
20 Pat Y(h)ea(h)h I(h) just felt it yesterday 'n
21 Doc: Does it hurt?
22 Pat: No?
23 (.)
24 Pat: No it's just a li:ttle ti:ny thing bu:t=I (.) figured I
25 sh(h)ou(h)ld l(h)et y(h)ou kn(h)ow .hhh i(h)f i(h)t was (on)
26 the same pla:ce, b't
27 Doc: So when you push [on it it doesn't hur[t.
28 Pat: [(Right.) [No it's
29 Pat: just a little- li:ttle tiny skin: [(tag) really.
30 Doc: [I: (.) see=
31 Doc: =Yeah it's different than whatchu had be[fore.
32 Pat: [Uh huh.
33 Doc: Your scar is up here,
34 Pat: Yeah that'[s what I figured (an-)
35 Doc: [An'
36 Doc: An' this is down below.
37 Pat: hh When he s- When he told me it was in the same place I
38 thought Uh: Oh: I better ca:ll a(h)nd te(h)ll yo(h)u .hhh
39 Doc: Ri:ght.
40 (.)
41 Doc: That's- I'm <ve:ry gla:d that you uh> did that.

A number of aspects of this patient's problem presentation exhibit a concern with the doctorability of her complaint:

1. In the headline of the narrative (line 1), she explicitly expresses some doubts that her complaint is doctorable and that her visit is justified. At most, the patient presents her problem as a possible problem.

2. She constructs her reason for the visit as a *narrative* and projects that narrative with an abstract or headline at line 1. Narrative is a device that can permit speakers to retain relatively strong control over the content and trajectory of their talk (Sacks, 1974). It provides the narrator with control over the content of their complaint and context in which it will be heard, and for this reason is often used in preference to submitting to questioning when persons are obliged to justify a need for service (Whalen & Zimmerman, 1990; Zimmerman 1992).
3. At lines 6, 8, 15, and 37, the patient invokes her husband, a third party, to bolster the validity of her decision to come to the physician with her problem, in effect co-implicating him in the decision to make the visit. At the same time, she disaffiliates (lines 15–17) from the judgment that she reports him as having made about as to the positioning of the "mole" that is worrying her.
4. When the physician starts to question her at line 11/13, she responds to him briefly in overlap, and then continues on with her narrative, refusing to concede to the interruption to the account-in-progress. It is unusual for a patient to compete in overlap with a physician, and to resist responding to a course of questioning that a physician initiates during the problem presentation (Beckman & Frankel, 1984). In this case, the patient competes with the physician specifically to express her doubts about the doctorability of her condition.
5. When the patient, at line 25, reports making her decision to come in for the visit, she inflects her talk at exactly that place with "breathy" laugh particles. Speakers have the capacity to do this very precisely (Jefferson, 1985), and the injection of laugh particles into talk is often associated with the reporting of "misdeeds" of some kind (Jefferson, Sacks, & Schegloff, 1987), especially in medical consultations (Haakana, 2001).

Up to this point in the patient's account, we have considered the issue of doctorability as a prospective one that can dominate the problem presentation phase of the consultation. Although this issue is particularly apparent during problem presentation, it can also resurface at later moments during the consultation. This is also shown in this datum. The patient's preoccupation with doctorability continues after the physician's evaluation at line 31, "Yeah it's different than whatchu had before." In particular:

6. The patient, who has positioned herself as skeptical about the nature of the problem prior to the physician's "no problem" evaluation, exhibits agreement with that evaluation (line 34).
7. Then, in redescribing the basis of her decision to come in for the consultation, the patient reinvokes her husband's judgment, and again infiltrates her report of the decision to make the appointment with laugh particles (lines 37–38).

8. The patient's redescription of the rationale for her decision has the effect of inviting the physician to offer reassurance as to the legitimacy of her decision to seek medical assistance, and he does so at line 41, by saying "That's- I'm <ve:ry gla:d that you uh> did that.".

Although, in this case, the patient's preoccupation with justifying the visit is clearly and vividly present, the same concerns emerge in more routine problem presentations. For example, routine upper respiratory ailments are often presented as being accompanied by symptoms that offer special justification for the medical visit:

(2) [Cold]
1 Doc: What can I do for you,
2 Pat: It's just- I wouldn' normally come with a cold,=but I
3 'ad this: co::ld. (0.4) fer about.hh >m's been< on
4 (Fri:day).=I keep coughin' up green all the time?

(3) [Flu - Expanded]
1 DOC: What's been goin' o:n?
2 PAT: I just got (0.4) chest cold a:nd it's been uh
3 goin' on for a week- I don't seem to be able to
4 [shake it-
5 DOC: [O:kay
6 PAT: → And uh what caused me to call is uh 'bout fourth
7 → or fifth day in a row in thuh morning- [I was
8 DOC: [Mm hm
9 PAT: → tryin' to get the engine started-
10 DOC: Mm hm
11PAT: → Coughin' up a buncha green stuff.
12 DOC: Oka:y.
13 PAT: So,
14 DOC: Oka:y .hh uh now have you had much in thuh way
15 of fevers or chills with this?

In both these cases, the patients refer to "green" stuff (purulent rhinorrhea) as a special symptom: the symptom implicitly justifies the visit because patients treat it as an index of bacterial infection for which an antimicrobial prescription is appropriate (Mainous, Zoorob, Oler, & Haynes, 1997; Stivers, 2002; Stivers, Mangione-Smith, Elliott, McDonald, & Heritage, 2003).

In other cases, the presentation of minor and potentially self-limiting symptoms is justified by past medical history:

(4)1[Strep Throat]
1 DOC: .hh U:m: (2.0) what's been goin' o:n.
2 PAT: Ah just achiness sore throat, an' .h I jus' thought
3 → rather than wait, um (0.2) I just have seen up a
4 → predisposition t' pick up strep throat durin' the school
5 year.=I teach kindergarten.=
6 DOC: =Oh you do.=

7 PAT: =So but thuh ↑school year hasn't [↑started yet,
8 DOC: [eh heh heh heh heh heh
9 heh ((laughs)) [.hhh
10 PAT: [I jus' thought rather than wait, °I want
11 to stop in and check.°

Or by reference to the advice of third parties, as in (1) above and (5) below, especially if the third parties have some kind of "medical" connection (6):

(5) [Sore Throat]
1 DOC: So you're having a bad sore throat huh.
2 PAT: → Yes:: um (.) a- a girl friend of mine kinda made me
3 → paranoid about it. =She said u:m (.) uh it could be
4 → strep throat but I've never had it before
5 [so I have no idea what that is but um (.) I was just=
6 DOC: [Uh huh
7 PAT: =explaining to her that my throat's been hurtin' up.

(6) [Asthma-like Symptoms]
1 DOC: You went camping and now have some difficulty breathing,
2 since the camping or something else?
3 PAT: → Yeah actually a friend of mine is a pharmaceutical sales rep,
4 → and she noticed the way I've been talking?
5 DOC: Okay.
6 PAT: I've been like (.) (breathing in) and she thought maybe I was
7 having some kinds of symp[toms.
8 DOC: [Okay.

In cases in which patients believe that their symptoms indicate a recurrence of a problem, they may risk self diagnosis as a short-cut to legitimacy:

(7) [UTI]
1 DOC: → How do you do.<
2 (0.9)
3 PAT: I got a 'U' 'T' 'I',
4 (0.2)
5 PAT: I think,
6 DOC: Uhh huh ((laugh)) £Okay look. that makes
7 my job easy,£ y(h)ou've a(h)lr(h)ead(h)y
8 d(h)i(h)ag[n(h)osed (h)it.
9 PAT: [I know.
10 DOC: hhh £Okay.£ .hh £have a seat over here.£

More complex still are narrative problem presentations that are predominantly occupied with displays of "troubles resistance" (Halkowski, 2006; Heritage & Robinson, 2006; Jefferson, 1988) in which patients are concerned to show that they attempted to manage their medical problem by watchful waiting or self-medication, and/or to document that the problem is outside their previous experience. In (8) below, the patient's struggle to explain his medical problem illustrates both of these elements:

(8) [Ringworm]

Doc: Yeah=I was lookin' through your chart before I
came in looks [like you've been a pretty]
Pat: [<Oh yeah>]
Doc: healthy g□u:y.□
Pat: (I've)- (.) pretty healthy, as far as I'm aware
of. ([ )]
Doc: [□Goo:d.□] Good [for you:.]
Pat: [Uh:]
Doc: What happened.
(.)
Pat: Oh I got_ (.) what I thought_ (.) in Ju:ne (.)
uh was an insect bite.=in thuh back of my neck
here.
Doc: Okay,
Pat: An' I (0.2) you know became aware of it 'cause
it was itching an'=I (.) scratched that,
(0.2)
Pat: An' it persisted fer a bit so I tried calamine
lotion,=
Doc: =Okay,
(0.2)
Pat: An' that didn't seem to make it go away
completely, an' it=s:tayed with me,=w'll its
still with me. Thuh long and thuh short of it.
Doc: [Okay.]
Pat: [Cut to thuh] chase is its- its still with
me, (0.3) but (its) got a welt associated
°with it.°
Doc: Okay,
(0.5)
Pat: Its got a welt that's (.) no:w increased in
size to about that big=it was very (.) small
[like a di:me] initially you know, an' now
Doc: [Okay,]
Pat: its (0.3) like a (.) bigger than a half do:llar
(I bet [it's like-)] [( )-]
Doc: [So you] [said it's] no: longer
itchy. Is [that correct,]
Pat: [O c c a :]sionally.

Here, the patient depicts an initial noticing of the problem about 10 weeks prior to this visit (line 11), depicts his becoming aware of it as the product of an entirely normal experience (Halkowski, 2006), and offers a routine and benign self-diagnosis as his first interpretation (Jefferson, 2004) of its cause (lines 11–12). Subsequently, he describes the persistence of the symptoms and his unavailing efforts at self-medication (lines 18–19, 22–24) and, bringing the time-line of the narrative into the here-and-now of the visit, he depicts his current symptoms as increasing in extent (lines 31–33, 35–36), and prominence (a "welt"—line 31). In all of these ways, the patient portrays himself as someone

(a) who would not ordinarily come to the doctor's office for no reason, and (b) who is suffering from escalating and unexplained symptoms. It may be added that the presentation of difficulties in interpreting symptoms opens up a second line of justification for medical visits—counseling for benign but unknown conditions. Thus, actual treatment is not required for the visit to be legitimated.

An overwhelming majority of problem presentations are built towards, and conclude with, the description of current symptoms (Robinson & Heritage, 2005). There is ample evidence that the presentation of current symptoms is designed to be the proximal point at which medical investigation begins and thus the point of transition into (usually verbal) history taking. If developing their concern as a doctorable problem is a primary task for many patients during the reason for the visit phase of the consultation, that task becomes somewhat less pressing after the doctor asks the first history-taking question. At that point, the patient's concern becomes "medicalized" by being reconstructed within a course of questioning that embodies a medical frame of reference. With the first-history taking question, the patient ceases to build the case for their concern alone and becomes a party to the co-construction of their concern as a medical problem. Thus, the first history-taking question provisionally validates the patient's belief that the concern is worthy of medical attention. The reason for the visit phase is occupied with a progression towards that bargain, at which point patients can surrender their control of the encounter in exchange for the medical questioning that prospectively underwrites the doctorability of their problems.

Although the validation of the medical visit as legitimate is ordinarily implied by a first history-taking question, it is important to underscore that this validation is provisional only. New information may emerge in the history that undermines the legitimacy of the concern, and the concern may be perceivably or actually delegitimated by diagnoses and counseling which do not match the patient's level of expressed concern. It is to these themes that we now turn.

History Taking and Physical Examination

Although history taking is ordinarily occupied with the co-constructive elaboration of patient symptoms into medical signs, the provisional validation of the patient's problem as legitimate can nonetheless remain problematic. As many have documented, history taking that is driven by differential diagnostic goals tends to be constructed using yes/no questions. The construction of these questions unavoidably involves setting agendas, and will also embody communicated presuppositions and expectations about the patient's circumstances and concerns (Boyd & Heritage, 2006; Mishler 1984). Thus, as Cassell (1985, p. 4) observed, "'taking a history' is unavoidably and actually an *exchange* of information."

This is particularly apparent when we consider that the design of yes/no questions, as social survey methodologists know only too well, must perforce incorporate indications of the likelihood or desirability of responses (Boyd & Heritage 2006; Heritage, 2002; Stivers & Heritage, 2001). For example, though some of the questions in the following example from a comprehensive history invite "yes" responses (lines 1 and 9) and some "no" (line 5), all of them are designed for, anticipate, and convey an expectation in favor of "optimized" or "no problem" responses:

(9) [History Taking]
1 DOC: → Are your bowel movements normal?
2 (4.0) ((patient nods))
3 PAT: °(Yeah.)°
4 (7.0)
5 DOC: → Tlk Any ulcers?
6 (0.5) ((patient shakes head))
7 PAT: (Mh) no,
8 (2.5)
8 DOC: → Tl You have your gall bladder?
9 (2.0)
10 PAT: I think so. uh huh=hh

Acute care histories are not exempt from this process. In the following pediatric case, the mother has presented her child's symptoms in terms of diarrhea and vomiting:

(10) [History Taking]
1 Doc: So it's (.) four da:ys? isn't i[t?
2 Mom: [yeah.
3 (0.7)
4 Doc: mtch.=ˉhhh o:ka:y
5 (.)
6 Doc: → A::nd (.) no blood with the diarrhea.
7 Mom: No.
8 Doc: (Just water[ ).
9 Mom: [( ).
10 (1.0)
11 Doc: How many times a da:y?

The physician's question at line 1 confirms the total period that the child has been experiencing symptoms, but her subsequent question at line 6—"A::nd (.) no blood with the diarrhea." (and its "reversed" follow-up "Just water" at line 8)—convey that this is an unlikely (and more serious) symptom. In Cassell's formulation (1985), information has been "exchanged" here.

A more explicit case is the following:

(11) [Diarrhea and Vomiting]
1 Doc: → ˙hh What's she bringing up?<any[thing exciti°n-
2 Mom: [(like just)

3 Mom: [Just fluid rea[lly,
4 Doc: [ˈhhh [hhh Just fluid.
5 Mom: [Nothing now. I don[ˈ- obviously I don't know what it was=
6 Doc: [Nuh- [ˈhhh
7 Mom: =earlier on, I wasn't her[e, you know,=
8 Doc: [ˈhh ˈhh
9 Doc: → =Right, but the: th I mean- n:othing nasty no blood er
10 → anything ˈhhh and the diarrhea: you say is quite (0.9)
11 Mom: Very strong, yea[h.
12 Doc: [Smelly.=What color is it.<is a hih![ˈhh
13 Mom: [A (.) a
14 white yuhh (0.4) yellowy

Here, the physician's question references the potential for the child to be vomiting something "exciting," but does so within the scope of the negative polarity term "anything" which invites a negative response. His follow-up question (lines 9 and 10) strongly indexes the seriousness of "blood" as a medical sign while conveying his expectation that this is not the case.

Although these serious medical signs are addressed in optimized questions that invite negative responses, questions addressed to core elements of the presenting concern embody what Stivers (2007) termed the principle of "problem attentiveness:" They are built so as to invite the confirmation of expectable medical signs. It is in this context that concerns with justifying the need for medical attention can re-surface.

In the following case, a child is presenting with an upper respiratory condition. The physician's "problem attentive" question at line 1 is responded to defensively by the mother:

(12) [History Taking]
1 Doc: 1→ Has he been coughing uh lot?
2 (0.2)
3 Mom: 2→ .hh Not uh lot.=h[h
4 Doc: [Mkay:?,
5 Mom: 3→ But it- it <sound:s:> deep.
6 (1.0)
7 Mom: 4→ An' with everything we heard on tee v(h)ee=hhhh
8 £we got sca:re.£
9 Doc: Kay. (An fer i-) It sounds deep?
10 (.)
11 Mom: Mm hm.
12 Doc: Like uh barky cough?

Here, rather than responding to the question with a straight "no" (Raymond, 2003), the mother gives a qualified negative response and then offers an additional characterization of the cough that goes beyond the terms of the question (line 5). Subsequently, she proceeds to elaborate on her concern as based on a television news report (which had described a case of meningitis in the area).

Paul Drew (2006) described this activity as "defensive detailing." Here, the mother has called the physician outside normal surgery hours, again in connection with a likely upper respiratory condition:

(13) [History Taking]
Doc: → Any problems with 'er breathing,=
Doc: =°(m[m,) n[o? no?
Mom: → [No:, [no she's alright she's 'er eyes are very red.
→ <'Er eyes are extremely bloodshot,
Doc: Mm hm,
Mom: → U:m: a::nd she's su- sayin' ow! all the ti:me, ehm
sort'u holdin' 'er stomach an' 'er head is very
hot (an') 'er ·hhh like a back an' (uh) (uh) chest
(an' uh)(·hh[h)
Doc: [Ri:gh[t,
Mom: → [An' then she's (sit) dozy now,

Here, the mother responds in the negative to a "problem attentive" question, but then proceeds to describe a range of additional and unasked-for symptoms, including the state of the child's eyes, the child's communication of stomach pain, fever, and so on. Notwithstanding the truth of these descriptions, their "defensive" presentation in the aftermath of the mother's no-problem response to the question about the child's breathing appears designed to convey the symptomatic foundations of her concerns, and hence to bolster the legitimacy of her decision to make the call.

Similar issues can surface in the physical examination. In the following case, the child is presenting with pain in the left ear which the mother has characterized as an "infection"—a formulation that implicitly lobbies for antibiotic medication (Stivers, 2002; Stivers et al., 2003):

(14) [Physical Examination]
Doc: Which ear's hurting or are both of them hurting.
(0.2)
Pat: Thuh left one,
Doc: → °Okay.° This one looks perfect, .hh
Mo?: (U[h:.???)
Doc: → [An:d thuh right one, also loo:ks, (0.2) even more
→ perfect.
Pa?: ( )
Doc: Does it hurt when I move your ears like that?
(0.5)
Pat: No:.
Doc: No?,
Doc: hh Do they hurt right now?
(2.0)
Pat: → Not right now but they were hurting this morning.
Doc: They were hurting this morning?
(0.2)
Doc: M[ka:y,

19 Mom: → [(You've had uh-) sore throat pain?
20 Mom: (°Yes°)
21 Doc: → Let's check your throat.

During the child's ear examination, at lines 4 and 6–7, the physician engages in online commentary (Heritage & Stivers, 1999; Mangione-Smith, Stivers, Elliott, McDonald, & Heritage, 2003) that projects a negative finding on the child's presenting concern. At line 9, the physician resumes the verbal history in pursuit of ear symptoms, designing his questions to facilitate affirmative answers. The child's negative responses are delayed (note the silences at lines 10 and 14) and hearably reluctant, and her final response (line 15) is a defensive justification for the visit (and possibly for being away on a school day). At this point, the mother interjects with a further symptom that could be pursued, and the physician takes it up at line 21. Here, online commentary projecting a "no problem" diagnostic outcome that is in flat contradiction with the child's reported symptoms elicits responses from both the child and the mother that function to defend the legitimacy of the visit.

Diagnosis and Counseling

The diagnostic phase of the medical visit is arguably the phase in which the physician's authority as an expert on disease and its treatment is paramount (Byrne & Long, 1976; Heath, 1992; Heritage, 2005; Peräkylä, 1998, 2002, 2006; Stivers 2005a, 2005b, 2006); however even here a "no problem" evaluation can engender patient or parent resistance. For example, in (15) the physician's announcement of a viral diagnosis and recommendation for over the counter medication (lines 1–5) is followed by the father's defense of the decision to visit the clinic—a defense that invokes the child's mother (who is not present) as a key decision maker (lines 8–12):

(15) [Diagnosis/Counseling]
1 DOC: → As you know they're v<u>i</u>ral infections, so there's
2 → no point in any a- any ant- antibi<u>o</u>tics.
3 (0.5)
4 DOC: → Simply control thuh cou:gh with .hh whatever
5 → your favorite cough medicine is,
6 (1.8)
7 DOC: #hmg hmg#=h[h
8 DAD: → [That's what I figured. (0.5) it
9 → was her m<u>o</u>:m who called. I said you got (tuh be
10 DAD: → k(h)idd(h)ing)he's probably- .hh heard about:
11 → couple hundred cases already=there's not much
12 → he's gonna be able to d<u>o</u>: so_

In the following case, the patient resists the physician's diagnosis on the grounds that the presenting symptoms only emerge at night (lines 6–11, 14–15):

(16) [Diagnosis/Counseling: Heath 1992]

Doc: Well yer ches:t is:: (.) absolutely cle:ar: today::,
(1.0)
Doc: which is helpful: (0.4) and your pulse is: (0.7)
only eighty .thhhh (.) which is er:: (1.2) not so bad.
(1.2)
Pat: → (Right it's::) there:: night time (uh) (.) it's:: 'ts
→ not clear there, I've got er::: ( ) (1.4) ( )
→ (0.3) I've more or less gone to bed when it starts: on us:?
(2.5)
Pat: → I wake all the way through the night without getting
→ any sleep (un open))
(0.5)
Doc: Mm
Pat: → (I don't know what's fetchin it up) during the nights (.) but
→ it comes in at the nights.

And in (17), which is translated from Finnish, a diagnosis that minimizes the patient's problem is resisted with an alternative diagnostic suggestion (lines 9–11), which the physician takes up (lines 12–15):

(17) [Diagnosis/Counseling: Perakyla 1998]

Doc: As [tapping on the vertebrae didn't cause any pain
and there aren't (yet) any actual reflection symptoms
in your legs it corresponds with a muscle h (.hhhh)
complication so hhh it's [only whether hhh (0,4) you
[((Dr lands on her chair.))
have been exposed to a draught or has it otherwise=
Pat: =Right,
Doc: .Hh got irrita[ted,
Pat: → [It couldn't be from somewhere inside then
→ as it is a burning feeling there so it couldn't be
→ in the kidneys or somewhere (that p[ain,)
Doc: [Have you
had any tr- (0.2) trouble with urinating.=
=a pa- need to urinate more frequently or
any pains when you urinate,

And in (18), the physician's (line 2) attempt to reassure a mother that her child's gastric symptoms are relatively non-serious ("Doesn't look like it's too significant,") attracts vigorous resistance:

(18) [Diagnosis/Counseling]

Doc: So it looks like she has an acute gastroenteritis:,
Doc: Doesn't look like it's too sig[nificant,
Gir: [( )
Mom: → °Okay: th-° .hh th- I was con[cerned cause uh-
Doc: [(And expect 'er-).
Mom: → Usually: if- she:- when she=if she vo:mits: she-
→ (0.8) it- it doesn't last as long or as o:ften.
(.)

9	Mom:	→	La[st night (was -)
10	Doc:		[('ts-) jus- jus' uh few throw ups an' that's
11			thee end of it. #Yeah [thee-#
12	Mom:	→	[Yea:h_ Like I
13		→	sa[y she was probably at least=h_
14	Doc:		[(It) was uh little u-
15	Mom:	→	It was at least ten [ti:mes.
16	Doc:		[(s- s-)
17	Mom:	→	[more like: ten to twe:lve (yeah.)
18	Doc:	→	[Sh #uh:#=yeah. well she had very significant=uh:
19		→	(5.5) Significant throw-up, but i:t=uh:
20	Mom:		[(Yeah [.)
21	Doc:	→	[.hh [there wasn't uh whole lot of bile in it so
22		→	she's not obstru- I don't (wanta th=[say)
23	Mom:		[No.
24	Doc:	→	.h[likely be ob[structed it_#
25	Mom:		[No. [No it was just once that [I saw [that.
26	Doc:		[.mlh [Or: uh°.
27			(2.8)
28	Mom:		°But=uh:=h° (0.5)
29	Doc:	→	Okay: every- An' everything checks out fi:ne,

Here, the mother invokes the unusual extent and frequency of her child's vomiting episodes (lines 4–7), together with the extreme nature of her child's symptoms the previous night (lines 12–13, 15–17) to rebut the physician's suggestion and, in the process, to defend against the imputation that she has brought her child to the physician's office for something that is not "too significant." In turn, the physician defends his comment by reference to a much more serious condition: gastro-intestinal obstruction (lines 18–24).

Finally, in the following case, the female patient has presented with a small cyst-like growth on the back of her shoulder. The physician announces that the growth is a "fatty tumor" (lines 1, 3), and reassures her that the growth is benign (lines 11, 14–15, 17–22), whereupon the patient invokes a third party as a determining factor in her decision to make the appointment (lines 13–14, 16, 18):

(19) [Diagnosis/Counseling]

1	DOC:	This is uh fatty tumor.
2	PAT:	.hh Is that what it is?
3	DOC:	(Right.) Uh little fatty tumor.
4		
5		...(7 lines omitted)
6	DOC:	Nothing tuh worry about.
7	PAT:	°Okay.°
8	DOC:	Okay?
9	DOC:	.hh They: .hh- (1.5) al:most never never (.) turn into
10		into cancer,
11	PAT:	°Mm hm,°
12	DOC:	And (0.2) they don't interfere with anything except if
13		they're so big #tha:t# (.) you can't lean on it or >ya know<

15 if they're big. Mechanical[ly they cause uh problem.
16 PAT: [Oh okay.
17 DOC: .hh But (in some sense) it's really nothing to worry about.
18 → <It feels just like fat. An' that's what it [is.
19 PAT: → [Yeah:
20 → th=somebody told me it might be that bu[t (they seh-)
21 DOC: [>(a fatty tumor)<
22 PAT: → (they said tuh go) (0.5)
23 DOC: (Yeah [w)
24 PAT: → [(ya know/have it) check(ed).
25 DOC: Right. That's what this is.
26 PAT: → .h I guess my concern was=('t)=since I had skin cancer
27 → befo:re,
28 DOC: Uh [huh,
29 PAT: → [they say you're at higher risk for getting: but it's in
30 → uh strange place tuh be_=
31 DOC: =Yeah >this is- .hh ya know< it feels like=h uh fatty tumor.
32 PAT: Okay.

Subsequently, the patient reveals her underlying concern (lines 20–21, 23–24)—having previously had skin cancer, she was entertaining a cancer diagnosis as a possibility. Given that the physician has explicitly ruled out this possibility early in the diagnosis at lines 14–15, this later reinvocation of a cancer diagnosis, while attracting a further round of reassurance (data not shown), also serves to bolster the legitimacy of the visit as a whole as one in which getting the lump "checked" (line 28) is the sensible and appropriate thing to do.

Conclusion

This chapter has offered a range of examples in which a concern with the legitimacy of visiting the physician's office is more or less apparent at the surface of the medical conversation. This concern is most transparently visible during the problem presentation phase of the visit. Here, the presentation of symptoms is almost unavoidably intricated with justifying the appropriateness of the search for medical care. However, as subsequent examples have demonstrated, a concern with legitimacy can and does surface at later stages of the medical encounter. This concern emerges most prominently when lines of questioning, comments during the physical examination, and reassuring "no problem" diagnoses and counseling renew the patient's sense that the physician may not be treating the decision to visit the surgery as fully justified. At such moments, patients can find themselves engaging in descriptions and observations whose import is transparently defensive.

The observation that symptomatology and morality are intimately intertwined is not a surprising one. For many years social psychologists have recognized that a description of a state of affairs is simultaneously a presentation of self. Since Jefferson's (1980, 1984a, 1984b, 1988; Jeffereson & Lee, 1992) work on troubles telling, we have known that the presentation of any personal

problem is circumscribed by very tight forms of normative regulation. And, in the special normative context of medicine in which the presentation of problems is fully justified, the operation of this principle of social life is particularly interesting. However the fact that physician and patient alike are first and foremost members of our ordinary society and bound by the quotidian norms of everyday life means that facts and morals can never be entirely separated in the medical encounter, and that the evaluation of these facts in the course of differential diagnosis cannot be fully separated from the moral evaluation of the patient. This unavoidable intertwining of medical expertise with normative and moral considerations injects a significant source of complication into the practice of medicine.

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