DOING OBSTETRICS: THE ORGANIZATION OF WORK
ROUTINES IN A MATERNITY SERVICE

by

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ABSTRACT

Despite popular and professional concerns with childbirth and prenatal care there are few empirical studies of behavior in hospitals where these events typically occur. The problem set for the study reported here was to observe behavior in the maternity department of a hospital and to provide a theoretical description of what was observed in terms relevant to sociologists' interest in the social organization of work routines of professional staff members serving a lay client population. The thesis is thus a description of medical staff members' work routines, with an analytic interest in how that relates to features of work routines of service occupations in general. Specifically, the study reports upon the ways lay patients may differ from professional medical staff members in their perspectives on prenatal care and childbirth and how staff members see these divergences as often resulting in organizational problems when they try to provide care which is "complete," efficient and expeditious. Further, the study describes how staff members develop interactional (and other) methods for managing patients, especially those who adhere to these non-medical perspectives, so as to cope with such practical pressures as the need to schedule patients and their demands, provide a visibly competent performance for superiors, peers and patients, and prepare the patient for efficient and expeditious processing at subsequent organizational stages. It is asserted that
these practical pressures (termed demand characteristics) are features commonly found in work routines of service occupations in general. Finally, it is argued that an ethnographic study of work routines of professional staff members of service institutions, e.g., hospitals, may be necessary to explain adequately features of apparently natural or biological events, such as childbirth, that occur within them.
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While others have contributed to this effort, the author alone bears the responsibility for the study.
CHAPTER I

INTRODUCTION

Perspective

In industrialized societies there have emerged specialized medical institutions staffed by "experts" and based on scientifically validated knowledge and techniques. Over the last fifty years (approximately), both the technical and administrative scope of these has increased. Biological processes are more extensively and comprehensively regulated by this administered knowledge now than they have ever been. Childbirth is one of the "natural" processes that has been an object of a great deal of control by medical science and institutions. As a result, modern obstetrical medicine is concerned with the birth of a child even before conception. Also, it attends to the "welfare" of the child prior to its actual birth. In other words, it treats these periods of a woman's life as medical events, i.e., it has notions of pre- and post-conception care. In fact, modern medicine tries to turn these and many aspects of the layman's life (however remote some of them may appear to be from childbirth) into medical issues and events, e.g., conception, birth control practices, dietary and exercise habits, specific methods of giving birth, and childrearing practices.

Anthropologist Margaret Mead has aptly described how
the high value placed on each individual life has been the premise for bringing folk and "primitive" childbirth perspectives and practices under the control of one uniform medical aegis.

From the great diversity of human practices, it is possible to see that childbirth has always been patterned. No known society has ever depended upon instinct to guide the mother or the other members of society. Infants have survived under a great diversity of conditions—e.g., where the midwife was another young girl, or where magical invocations rather than midwifery skill were depended upon. The family has survived whether the father was banished for a month, whether he was expected to sit behind his wife and provide a firm human support for her labor, whether the father was expected to observe the taboos before and after childbirth, or whether the childbirth only involved the mother and other women. All the human societies we know would not be here if some human infants, some mothers, some fathers, some brothers and sisters were not tough enough, healthy enough, and flexible enough to meet these variously contrasting styles of social behavior. But in the societies of the past, only a few babies lived, sometimes less than half lived. Today we are developing a style of life in which our aim is to save almost every baby. We are no longer dependent upon the fitness of the "nursing couple." A mother whose child does not thrive on her milk need not watch her child sicken and die since there are formulas to be used. A mother falls ill and must wean her child does not endanger his life. As we save more and more infants we need better methods; not only technically improved methods of delivery; not only technically improved methods of delivery, and technically improved methods of encouraging breastfeeding and special artificial feeding, but also better provision for the social situations in which a young couple faces parenthood, and for all the children who must welcome a new baby into the family.1

Mead herself implies approval of the increasing institutionalization of medical control over "styles of social behavior" in childbirth and even in the new family's relationships. On the other hand, she also suggests that strictly speaking, it is not the survival of the human race or even of
a society that warrants this control, but just the culturally specific concern for infant mortality *per se*. Mead's reference to the medical perspective on childbirth as a "style of life in which our aim is to save almost every baby" suggests that it stands as just one of "variously contrasting styles of social behavior" that has existed in societies.

Within the medical perspective itself, specific approaches to prenatal care and childbirth may change according to "new scientific discoveries." However, what this simply entails is more frequent changes in the content of rules governing events in childbirth compared to those of folk and "primitive" cultures and subcultures. For these "backward" members, pregnancy and childbirth frequently is not a health problem. For these events, according to Mead, there exist certain rules over diet and other activities. In industrialized societies, particularly, these rules have been medicalized, as Mead herself implies. The rules have been displaced to frame the member's life from conception through birth and motherhood. As a result, medicine sees as its domain (e.g.,) what members do for a living and their child rearing practices. The professional medical literature itself can be cited to support the assertion that medical practices and goals in regard to childbirth constitute a collection of rules based on culturally specific value premises. The following professional writer, a nurse, discusses the fact that whatever the source for specific changes in obstetrical practices—scientific discoveries, or "taboos" borrowed from "primitive" cultures--
modern medicine adopts them as moral prescriptions and pro-
scriptions ("dogma" and "duties") and institutionalizes them in hospital routines and prenatal regimens.

At each stage as we make new scientific discoveries, we find that the attempt to use them differs from culture to culture, and that we need to be continuously aware of how a scientific discovery will be used in a given culture. Just as we earlier turned maternity into a duty, like eating the right food, women are now attempting to turn the new freedoms of giving birth to a baby without an anesthetic if there are no complications, or of breast feeding their baby if he and the mother flourish, into new oughts. As a consequence, women are developing extreme anxieties if they do not have "natural childbirth," fail to breast feed, and cannot manage "self-demand."

Unless we realize that matters of health in our culture are closely tied to duty and conscience—we ought to eat the right food, get enough vitamins, have enough sleep, take the right exercise, watch our weight, relax—we fail to understand the kinds of anxieties that any changes in maternity behavior introduces. Childbearing generally in America is not an intrinsically rewarding, pleasurable experience in which a woman expects to take an immediate, day-to-day delight. Instead, it is a series of necessary, hygienic, difficult, and unrewarding activities which will culminate in a child who can then be enjoyed only to the extent that he grows, gains weight, learns to walk and talk, establishes good toilet habits, takes naps, plays in the fresh air, and goes to bed on time.²

On the other hand, social scientists have pointed out how in some contexts the professional and organizational structures delivering this extended scope of medical care is "imposed" on a population whose ordinary health care practices do not correspond to or fit with the technical and/or administrative rules and requirements of its organization. In other words, researchers (and health personnel themselves) have found that some people have not been trained to "want" its services or do not know or do not want to know how to participate as properly competent receivers of the routine delivery of its
services (medical personnel may pejoratively call them "bad patients" as a result). Thus, the practice of obstetrics, as well as other medical specialties, may take place in cross-cultural (or cross-subcultural) scenes wherein there are problematical relations between professional administrative/technical routines and people who do not subscribe to them.³

Social scientists attribute patients' "resistance" to medical control to several "cultural variables": (1) their subscribing to subculturally prescribed traditional and folk methods of health care (medical personnel call them "old wives' tales"); (2) their subscribing to subculturally prescribed notions (differing from medical staff) of how to behave while playing the "sick role," due to differing backgrounds (from medical staff), including social class, ethnic, educational, and even occupational differences (especially in their accepting preventative "care").⁴ Furthermore, one medical sociologist, Eliot Freidson, even implies that medical personnel often have difficulties getting patients to cooperate fully in accepting treatment, due to the almost inevitable differences between the lay client perspective and that of the professional health personnel.

Medicine is a consulting, not a scholarly, profession. The bulk of a consulting practitioner's work relationships involves clients, not colleagues. Clients, unlike colleagues, are not usually in the same social world as the professional. Clients, therefore, do not "speak the same language" as the professional; the two do not share the same phenomenological meanings, assumptions, or concepts. Illness never means the same thing to the client and to the professional. Everett Hughes put his finger on the most obvious difference between professional and client perspectives when he said that what was routine to the
professional was an emergency to the client. The client, however, can ignore or handle his emergency himself if he so wishes. The professional, on the other hand, needs clients to carry out his work, to apply his knowledge, to practice his calling. He must persuade clients to accept his ministrations or be able to place them in a position where they have nothing to say about the matter.

Professional practice cannot exist without clients, but the influence of the client over the professional does not end with that simple dependence. . . . medical practice owes much of its variety and patterning to the type of client dealt with. This is not to say merely that clients of different classes, cultures, or degrees of cosmopolitanism present the practitioner with a variegated work life. The power of the client goes much deeper than that . . . different types of clients make different demands on the practitioner, and the way he meets these demands significantly shapes his routines of work. (my emphasis) . . . The everyday work life and the social identity of the professional are thus intimately related to his clientele.

. . . . the professional's autonomy over his work (is) hard won, as (is) his social prestige . . . analyses of the effects of clients on professional work indicate that autonomy and prestige must be carefully nurtured every working day. As a result, many professional activities are probably best viewed as stemming from a conflict over control of the situation. The particular form this conflict takes depends on the relative social status of professional and client, and on the extent of institutionalized control the professional wields, but in a symbolic sense, all patients are idiots to professionals.5

Here Freidson can be seen as indicating the importance of studying patient management techniques in any analysis of medical personnels' work routines. He appears to be espousing this analytical approach on the grounds that the cross-subcultural (and other) differences between lay clients and professionals will often result in conflict when medical personnel try to "recruit" patients for treatment and try to gain their cooperation when they do come for treatment. Thus, professional doctors (and presumably other medical personnel)
develop methods of (as Freidson puts it) "managing patients," which . . . "significantly shape (their) routines of work . . . . ." In fact, it is the purpose of this thesis to show how such methods significantly shape obstetrical work routines and especially how these methods themselves are shaped by practical work "pressures," such as those glossed by Freidson as a professional's concern for "autonomy and prestige."

Besides the research literature, the published accounts of working medical professionals themselves can also be cited to show how they may struggle with "recalcitrant" patients, e.g., those subscribing to traditional and folk "old wives' tales" governing prenatal and post-natal care, as well as other subcultural notions seen as "antithetical" to the professional medical perspective. In other words, these "behind the scene" accounts also suggest issues of cross-cultural or cross-subcultural conflict between medical personnel and patients (e.g., diet, styles of delivery, exclusive use of medical sources for advice, etc.) as well as the ways personnel try to organize their work routines so as to manage "bad patients" and bring them into compliance with technically and administratively required "treatment" routines. For example, a private obstetrician relates his experience of having to establish a clinic in an "urban ghetto" to try to overcome the members' view of childbirth as a non-hospital or non-medical event. As he describes it, this "ghetto" was populated by blacks, Puerto Ricans, and "poor whites," most of whom were unemployed or on welfare. Mothers-to-be from this area had caused a hospital
"problems" by appearing there only as emergency cases, tying up much of the facilities and disrupting the staff members' work schedules. Again, this doctor reports that members of these cultural groups regarded the hospital only as a place to die. By moving prenatal facilities to the "ghetto" it was hoped that they would not be frightened away by the hospital milieu and would use the prenatal clinic to a much greater extent. However, this doctor found that the members of the neighborhood still "neglected" to use medical resources during the prenatal period or made "poor patients" in adhering to medically prescribed prenatal routines of "preventative care" and in keeping their appointments for regularly scheduled check-ups.

Even more of a barrier than fear and superstitution was simple apathy. The poor, largely ignorant people looked upon pregnancy and birth as natural processes, not much more complicated than eating, and nothing to get excited about. If a prospective mother developed health problems, that was just bad luck or, perhaps, a curse. The symptoms might be terribly interesting and worth gossiping about, quite unrelated to the fact that she might be suffering from anemia, toxemia of pregnancy, diabetes, syphilis, or tuberculosis. It was taken for granted that quite a few babies would be born prematurely, stillborn, or retarded. The more religious tended to look on such wastage as the will of God and a matter for prayers, not medical attention.

Because I've seen the deadly effect of impersonal assembly-line medical attention in military service, I treated the patients exactly as I did those in my private practice. I kidded with them, raised hell if they didn't follow instructions, and kept a close check on their progress. We paid great attention to follow-up: If a patient missed a regular appointment, a nurse called her to find out why and to reschedule her. We even sent out aides to make sure that the patient showed up next time.

... With ghetto patients, as opposed to my private ones,
I found that giving instructions on diet or medication wasn't enough. Many of my center patients simply couldn't help cheating on their diet and seemed to feel that if they could fool the doctor, the effect on themselves and their baby wouldn't count. I had an answer to this. When I discovered that they hadn't followed orders, my **achtung** spirit rose, and I slapped them in the hospital, where they couldn't cheat, until their blood sugar levels declined.

In a way, I suppose, I was playing God in the ghetto, but in a positive way, making decisions that enabled life to improve itself. On the whole, it was a highly satisfying experience.

This working obstetrician's account suggests that medical personnel may routinely coerce, castigate ("... raise hell ..."), and generally hold members accountable for their non-medical perspectives and practices. His remark on "... playing God..." to improve life also suggests that medical staff try to exercise this moral control over patients in order to transform them into "good patients" and proper prospective mothers. He implies that in the medical perspective each individual life is valued very highly, while recognizing that it may not be in other segments of industrialized, Western society. Indeed, he implies that medical personnel see it as their mandate as medical professionals to try to teach "resistant" patients a professional medical view of proper pregnancy, childbirth and motherhood, and thereby try to produce "good patients" who conform to established organizational work routines.

In sum, there is a so-called "medical" view of conception, prenatal care, childbirth and post-natal care which contrasts with various cultural, ethnic, and general lay views of these events and phases and their significance. While it is
posed as a "medical" view, in fact it can be argued to have a thoroughly moral and culture-bound set of ingredients, e.g., views of "proper" family life and spouse relations and responsibilities; "proper" orientations to the future, occupational progress and ambition; the future life style and "rights" of the unborn child, etc. Since the medical view contains such components—i.e., matters which do not require medical training, but are culture characteristics—patients obviously differ in the extent to which they seem "accepting" or "resistant," and thus they get characterized in moral terms although the treatment is as though only medically relevant matters are at stake.

In other words, among staff members at City Hospital, where I conducted the study on which this thesis is based, (and presumably at other hospitals as well) there is a relatively clear set of views on conception, pregnancy, labor, childbirth and care which add up to an "ideology." Nevertheless, staff members at City treat this set of views as a medical matter which they have a mandate to enforce. This medical ideology is seen as making strong moral claims on societal members and leads to a view of the well-programmed patient. However, the society does not necessarily produce a steady flow of such "ideal" patients. Staff are thus faced with what from their perspective, rooted in work, professional and organizational routines and belief systems, must appear to be "recalcitrant" patients. Staff thus develop views and procedures for "shaping" the recalcitrant in the image of the "good patient." As a result, some contacts with patients provide for the development
of occupational routines which focus on "teaching" patients to adopt such views, and which serve to detect patients as, e. g., morally derelict if they choose alternative arrangements, are indifferent to matters which staff view as "essential," etc. Thus, some contacts allow staff to map sharing the "proper perspective" into compliance with specific behaviors, plans, expectations, etc. The operation of the ideology thus displays patients as, e. g., "ignorant," "culturally backward," etc., and motivates staff to "work on" patients so as to bring them into greater conformity with the image of the good patient--she who gives promise of adapting to and accepting organizationally bound requirements.

From the staffs' point of view, then, there may be much to "teach" patients and certain ideologically prescribed ideals of how they should be treated, e. g., as individual "persons" with their own self-defined "needs," deserving of respect and propriety. Nevertheless, work exigencies make strong claims on various categories of staff in a hospital (supervising physicians, medical students, nursing personnel, medical social workers, etc.) which sometimes reinforce the ideology and sometimes conflict with it. In other words, despite the sometimes explicitly verbalized coherent set of views which good patients should share with staff and staffs' espousal of ideals of respectful and proprietous treatment of patients, in the course of managing the work flow, satisfying hospital regulations, accommodating the doctors' work flows, students' teaching needs, etc., adequate conformity in a
procedural sense is more important to staff than attitude shifts and proprietous "individual" treatment, and sanctions are often directed at obtaining such conformity. In conclusion, the "medical view" has implications; i.e., it translates into a set of routines, procedures and activities which are taken to implement it. When you look at such routines and procedures in detail you find, of course, that not only are they urged, defended and practiced under the auspices of a concern with, e.g., "health," but that they have their own exigencies (or demand characteristics) as organizational events and work-related activities and routines. It is this general topic of the implementation of a medical ideology in the management of pregnancy and childbirth via organizational and occupational demand characteristics and their attendant problems which I wish to examine in this thesis.

More generally, I intend this thesis to be an ethnographic examination of this topic which will stand as a study of the organization of work routines in a "people-work" organization. I will attempt to follow the works of Sudnow, Goffman, Cicourel, Zimmerman, and others which have analyzed the methods and procedures whereby professional "servers" have tried to implement a professional ideology or belief system in their work routines with (often) "troublesome" clients while, at the same time, attending to organizational and work exigencies, e.g., the maintenance of a manageable work schedule and providing a visibly competent performance for clients and
superiors. As in those studies, my primary focus will be on discovering and describing the routines and procedures staff members develop to manage and "work on" such patients (clients) so as to bring them into greater conformity with the image of the good patient—she who gives promise of adapting to and accepting organization-bound requirements—or at least to coerce from them conformity with established "treatment" procedures. This study, then, will deal with staff and medical personnels' problems in managing a population of transient clients, who often have "deviant" or divergent views from those of the staff on the kind and quality of "service" (treatment) they should receive from the organization, and who are not subject to long-term enforcement procedures. Also, in comparison to other "people work" organizations, distinctive problems of management are created in part at least by virtue of the fact that staff are dealing with a process--labor and childbirth--that is not wholly controllable and does not fit neatly into work routines, although the work is typically carried out in organizations with quite fixed procedures and a momentum that is not entirely geared to patient "needs."

More specifically, the organization of shiftwork, the requirement that a physician be in attendance at delivery, etc., are organizational arrangements and ideologies that are perhaps somewhat at odds with labor and childbirth viewed as "natural" processes. As a result, the staff develop patient management techniques to try to bring labor and childbearing patients
into greater conformity with the image of the "good patient," whose labor and delivery "fits" into organizational and occupational routines and ideologies. However, as with management techniques employed in delivering prenatal care, these control routines rely on interactional and physical methods which may be seen as causing "problems" by patients and other outside observers, such as researchers: the frequent use of anesthesia, caesarian sections, artificial inductions of labor, "teaching" the patient to "hold" the baby back from being delivered, etc., (although such "problems" may often be mistaken by outside observers as resulting from the processes and attributes of the patient). In other words, the ideals of medical ideology support the servicing of the individual childbearing patient's "needs" (and the avoidance of such "problems") while in fact those ideals will only sometimes be actually implemented in staff's everyday work routines, depending on their particular work exigencies or demand characteristics. Not all of the routine patient management techniques I will describe in this thesis will appear to "violate" ideals of the medical ideology, and, in fact, the goal of the thesis is to describe any and all such techniques I discovered in my study, but not to show how frequently staff's application of the ideology in the context of everyday work pressures constituted a threat to "good" patient care, however that may be "measured."

The Sociological Literature

Although a great deal is known about the social
features of certain biological events (e.g., blindness, death, etc.) and certain transitional states (e.g., adolescence, aging, etc.), little is known sociologically about childbirth and childbearing as a social process. This is not to say that childbirth has not been studied as an event. Anthropologists have been collecting data on the socio-cultural features associated with childbearing and childbirth for many decades. For the most part, the sociologists who have concerned themselves with childbirth have been concerned to demonstrate quantitatively significant relationships between medically defined phenomena and social characteristics of patients as they are perceived by sociologists. Numerous studies have shown that apparently statistically significant relationships exist between the pathologies of pregnancy and birth, pregnancy and birth events and such social characteristics of patients as social class, race, age and marital status. As a result, medical sociologists expect from the nature and direction of these relationships that medical phenomena be class-related: (e.g.,) higher socio-economic groups have lower frequencies of pathology than lower socio-economic groups.

In focusing their attention on these studies of social-medical relationships, researchers, with only a few exceptions, have ignored the social setting and the personnel within that setting which have a direct bearing on the reproductive process. When this commonly-occurring biological activity takes place within the confines of a hospital it comes to involve the clinical and social activities of numerous
hospital personnel ranging from ward clerks and secretaries to
gynecologists and obstetricians. "Having a baby," no matter
how simple or complex biologically, entails a variety of occu-
pational specialists engaged in a concerted social activity.
In sum, researchers have generally taken for granted that the
events of childbirth and prenatal care are technical or "objec-
tive" outcomes determined by the "objective" biological condi-
tion of the patient and, to a more limited extent, her "social
characteristics" (as well as those of the medical staff who
"treat" her) which are "external" to the organizational setting
where these "natural" events occur, e. g., the patient and
staff's standing in a sociologically-defined social stratifica-
tion system.

On the other hand, there have been a comparatively
small number of medical sociologists who have provided for the
organizationally situated character of "natural" events in the
hospital. Mainly their analyses have drawn heavily from the
following schools of thought in sociology: ethnomethodology,
symbolic interaction, and dramaturgical analysis. With
regard to events surrounding childbearing and childbirth, I
have found the work of David Sudnow, an ethnomethodologist,
particularly significant--specifically, his discussion of how
the practical structure of occupational and organizational
routines shape events in the delivery room. His interest in
these events was generated by a general concern for death and
dying as organizationally situated events. Thus, his focus is
limited for the most part to the organizational routines staff develop to deal with natal "distress" and death in the delivery room.\textsuperscript{15}

I believe the works of another ethnomethodologist, Roy Turner, can also be seen as providing a useful analytical framework for examining the organizationally situated character of "natural" events, such as childbirth. For this purpose I found most illuminating his analysis of how the outcomes of encounters between police and "offenders" may be significantly shaped by the practical structure of the police's occupational routines.\textsuperscript{16} In fact, in trying to sort out and analyze the salient features of the hospital activities I observed in my field work, I was guided to a great extent by Turner's formulation of an ethnomethodological approach to studying events that occur in professional and other occupational settings:

\ldots{} I have suggested that the properties of police work that I have discussed are generalizeable to other work settings. Indeed, I believe that ethnographic studies of professions and occupations, identifying, describing and analysing demand characteristics and occupational routines, will uncover significant and invariant properties of stable social arrangements that are taken for granted. In particular, I believe that such studies are useful with respect to those occupations where established ideologies and lay belief systems encourage the view that practitioners—e.g., physicians, scientists, psychiatrists, social workers—do not, or "ought not" to shape their work activities in accordance with such mundane considerations as the structure of the work day, the visibility of work, etc.

\ldots{} I am suggesting that ethnographic studies of science, medicine, etc., will have as their pay-off not critiques and remedies, but some more fundamental understanding of how these activities are constituted in the first place. My theoretical interest in advocating such studies, is to disclose, not the "social influence upon," but "the social structure of" the central events and activities of the
professions and occupations. Like David Sudnow, I am advocating a concern with "the procedural basis of events," and "the concrete organizational foundations" of activities. To put it another way, laymen possess common-sense knowledge of, and normative concerns with, the "technical" events and procedures of practitioners—such events and procedures as "diagnosis," "arrest," "therapy," "treatment," "experiment," etc.—and sociologists are given to treat these as "context-free" matters, about which inquiry can be conducted without in the first place clarifying such matters as organizational products. 17

Also, in trying to analyze the collected observations from my study of this hospital I found useful Donald H. Zimmerman's ethnomethodological ethnography of the work routines of intake and eligibility social workers. 18 In particular, I was impressed with his discussion of how such practical considerations as scheduling clients (especially "bad clients") and providing a competent performance in the eyes of superiors (i.e., what Turner termed "demand characteristics") led social workers to modify a professionally-supported ideal ideological approach to servicing and managing clients. Also, I found useful his discussion of how experience in managing clients also leads to some extent to the adoption or application (or not) of this ideal approach to client management (as opposed to a more work-located approach). Thus, it was from Zimmerman's work that I drew the notion of two approaches to patient management and "care"--one professionally and ideologically ideal, the other located in the everyday work setting.

From another ethnomethodologist, David Sudnow, I derived an interest in analyzing staff's perspective in terms of typifications of patients and events in the hospital as
"normal events," which serve to organize their work routines so as to cope with demand characteristics, especially the scheduling of work. Also, I found very useful Sudnow's brief analysis of staff's patient management techniques in delivering "bad news" (or not) in the delivery room.

Thus, in drawing from the literature and theory in sociology I owe the greatest debt to the works of ethnomethodologists: Roy Turner, Donald H. Zimmerman, and David Sudnow. Indeed, it is from their works that I drew my central theme: seemingly "technical" or "natural" events in the hospital (e.g., "prenatal care," "labor," and "childbirth") are shaped to a significant extent by the staff members' work routines (especially those involving patient management) which they develop to cope with the practical structure (e.g., demand characteristics) of their everyday work. In pursuing this theme I will follow a theoretical approach which is very similar to that of Turner and Sudnow: I will seek to analyze actual on-going interaction between hospital staff members and patients in terms of its constitutive, concrete organizational procedures and methods. This approach attempts to describe how for staff members in their everyday occupational routines patient management methods constitute a significant part of the procedural definition of obstetrics. In other words, I suggest that these heretofore undescribed methods to an important degree constitute "doing obstetrics" for staff members in this hospital.
The Hospital Setting

City Hospital is a large general, private, acute care referral hospital incorporated by the province around the turn of the century. Its business affairs are managed by a board of volunteers ("trustees") who represent the governments of the Western Canadian province and city in which it is located, as well as a university medical school and the Hospital Corporation itself (half of the board is comprised of the latter). Policies of the Hospital, as approved by the board of trustees, are administered by a salaried director.

The Hospital has a total capacity of approximately 1,800 child and adult beds. Its employee staff exceeds 3,500. Approximately 900 doctors comprise the medical staff. The graduate nursing staff is approximately 800 Registered Nurses. In the Hospital's thirty-five operating rooms approximately 45,000 operations are performed annually. More than 48,000 treatments are given in the emergency department and more than 44,000 patients are admitted to City in the course of a year. Approximately 40 percent are referred from areas beyond the city in which the Hospital is located. An adult outpatient department gives diagnostic and treatment service to "low income" persons upon referral from a doctor or a welfare agency. About 61,000 patient consultations are conducted during the course of a year. Among the busiest of this department's clinics are general medicine, dermatological, psychiatric, eye, obstetrics and gynecology.
One of the settings for my research is the obstetrics and gynecology outpatient clinic, which is located in the ground floor of the obstetrics and gynecology building. A Hospital publication describes its obstetrics department as occupying a position of eminence among medical institutions, recognized as one of the foremost maternity centers. Here the skills of the most able specialists, performed with the aid of modern facilities and services, assure the expectant mother of the finest medical and surgical care. It is literally the meeting place of about 3,200 newborns and mothers each year. In this happy patient area there exists an understanding and an intimate relationship between mother, nurse and child.

(A full description of the clinic and the delivery floors, setting for my research, may be found at the beginning of Chapter II, along with diagrams of the floor plans of these two floors.)

City engages in a large medical training program which it describes as "... a ranking educational program for professional and technical personnel for specialized assignments in the medical field--one of the great medical teaching centers." This program is closely associated with a school of medicine of a nearby large university and an institute of technology. More than 800 students from those two institutions are enrolled in courses for various types of technical specialties as well as post-graduate medicine and surgery. City Hospital itself maintains a school of nursing with a student body exceeding 500 (one of Canada's largest). Student enrollment in the above three institutions is representative of practically every area of the globe, especially the Commonwealth
countries.

Of the Hospital complex of sixteen buildings the largest was built in the late 1950's and has an occupancy of 504 beds. It is an ultra-modern ten story building with a total of eighteen operating rooms, including four emergency operating rooms located in its emergency department. In stark contrast, next to it is the much smaller obstetrics and gynecology building. It is a drab four story building built in the late 1920's with an occupancy of 111 beds, plus 119 bassinets for new-born babies. (A more detailed description of this building, site of my research, may be found at the beginning of Chapter II.)

The university's school of medicine maintains a research department at City, dealing particularly with problems of the new-born infant. In fact, it was through the Hospital's affiliation with the school of medicine that I gained access to the obstetrics and gynecology department. However, a high level administrator informed me, by way of orientation to this department, that it (like most departments in the hospital) was primarily oriented to servicing the health needs of the community, although he "likes to support research" in the obstetrics and gynecology department. Thus, at least in the department which was the setting for my field work, work routines were developed and maintained primarily to provide efficient servicing of patients and teaching, rather than to encourage and facilitate research (particularly that related to social science). In the following section, describing my
data collection, I will show how this service and teaching orientation to some extent affected my access to this setting, particularly the labor and delivery area.

**Methodology**

Initially, my choice of childbirth as a topic and non-participant observation as a method resulted from my reading Sudnow's brief ethnographic description of doctor-patient interaction in the delivery room. Also, my choice of an ethnographic method was strongly influenced by Roy Turner's study of police occupational routines (briefly described above). In that paper he argues for an ethnographic method that tries to provide as data a continuous and un-edited record or "videotape" of social phenomena, i.e., a method that tries to describe and account for commonplace features of an actor's on-going organizational life.

A common sociological response to these concerns (lay criticisms of "helping organizations"--J.E.F.) is to seek to identify and make sense of the "variables" that might account for, e.g., police failure to give all categories of citizens equivalent treatments, whether as victims or suspects. As opposed to such an interest I want to try to describe and account for some of the commonplace features of daily police work that provide for lay criticisms. I realize that this will disappoint at least two sets of readers, those who look for redeeming social significance in sociological descriptions--of the kind advertised in such titles as *Minorities and the Police: Confrontation in America*--and those who look for sociological data to be cast into the moulds of classical issues, such as the explanation of the growth of "informal" practices within a context of "formal organizations." Nevertheless, I must endorse Jack Douglas's characterization of sociologists' practice of substituting phenomena of their own construction for those of common-sense everyday life and then studying their own *ad hoc phenomena* as if these constituted "reality." They have done this in part to
avoid the complexities and "biases" of common-sense terms, but the study of their ad hoc reality has simply created another level of complexity: since they have still wanted their studies to be ultimately related to everyday life they have had to shift back and forth between their ad hoc phenomena and the everyday phenomena, constructing post hoc systems of translating devices and other devices.

As I see the application of Douglas's remarks to studies of the police, neither the social-problems nor the traditional theoretical approaches have adequately resolved the fundamental procedural issue of how their constructs are related to the "everyday phenomena" of socially-organized police activities. To put it metaphorically, such studies proceed by the assembly of "snapshots" of the social world: it is not hard, for example, to assemble snapshots demonstrating police "prejudice." Of course, my concern here is not to argue that "police officers are not prejudiced," any more than it is to affirm such a statement. To continue with the metaphor, my concern, rather, is to suggest that a continuous and un-edited videotape of social phenomena requires quite different constructs for adequate explanation than those that may satisfy data consisting of a selected assembly of snapshots. These are complex issues, of course, and I am afraid that I must leave them at this point with just one illustration. My own field observations could readily have produced a snapshot of a juvenile officer talking to or apprehending a young Negro, such that "prejudice" would be fairly well evident. But then if the operation of "prejudice," or the attribution of "negative attitudes towards Negroes" to the police, is to be raised to the level of an explanation of police behavior, what are we to say concerning another datum which only a continuous movie or videotape record could disclose--namely that the very same juvenile office optionally organized an evening's patrol in such a way as largely to stay out of concentrations of Negro population, choosing instead to patrol white neighborhoods?24

In sum, in choosing a method for this thesis research, I felt, like Turner, that nothing short of an attempt to observe staff members' prenatal and childbearing procedures "in motion" would suffice for an adequate study of these phenomena.

In order to obtain a continuous, on-going view of staff members' activities in situ I attempted to integrate my research activities into the natural rhythm of activities in the
hospital setting by accompanying or "shadowing" them as they went about routine interaction with patients. In this fashion, the primary control over what was observed would presumably be exercised by the normal work routines in the setting. The field of observations would consist, then, in any and all activities and events encountered in the course of tracking personnel.

In gathering ethnographic observations for this study I spent six months as a non-participant observer in the outpatient clinic and delivery floor of the obstetrical and gynecology department of City Hospital, a large general hospital servicing both "private" and "public" patients in a large city of Western Canada.

Basically, the bulk of the time spent there was devoted to simply observing and recording interaction in the three areas of the department where I found the most sustained contact between patients and staff members and thus were scenes where patient management routinely occurred: the intake or waiting area of the outpatient clinic located on the ground floor of the obstetrics and gynecology building, the cubicle area to the rear of the waiting area where pelvic examinations and medical interviews were performed, and the delivery rooms, the site of childbirths, which were located on the top or fourth floor of this building. In these three areas I sought to get close to occasions where medical interviews were conducted, pelvic examinations performed, and babies delivered, record what transpired in the behavior of staff members and their interactions with patients, and analyze some of the general features
of that behavior. I was introduced, by a high-level adminis-
trator to the personnel in charge of these areas, as a "socio-
logist studying the social organization of childbirth in the
hospital." Gradually I became acquainted with most of the
staff members in these areas. While I sat on the waiting
benches in the intake area, I was not required to wear a
hospital uniform. At those times I usually dressed in a
sweater and slacks. When accompanying staff while they per-
formed the taking of medical histories and the physical and
pelvic examinations I was required to wear a white intern's
jacket over a white shirt and tie. While observing in the
delivery rooms, I was required to wear a sterile green surgi-
cal gown, cap, shoe covers, and a white face mask. The hospital
staff dress made me less subject to questioning by staff
members; but occasionally patients would address a variety of
requests to me including asking directions to other parts of
the hospital and news of the condition of a relative who was a
patient. However, there was a continually high turnover of
student nurses and doctors from the nearby medical school with
which City was affiliated and from which it drew a significant
amount of its labor supply. Normally a group of students would
spend only six weeks in each Department of the Hospital. Thus,
sometimes it was not possible to be introduced to all of them.
As a result, occasionally they would ask me technical questions
about anatomy and various gynecological diseases or request my
assistance in the cubicle area and the delivery room. They
apparently assumed from my intern's jacket or green surgical gown that I was their superior in authority and experience. When such occasions arose, I usually introduced myself as a research medical sociologist studying the "treatment of obstetrical patients in the hospital." The student would then usually shift his questioning to my research or request the aid of "another" staff member. Occasionally, I would accede to the request for aid with a minor task in order to further make my presence a natural part of the scene, after introducing myself. Sometimes I would be compelled to aid in some minor task without the opportunity to introduce myself. For example, on one occasion while I was standing by in the delivery room a patient who was just about to deliver started to bleed from a puncture wound made in her arm by an intraveinous injection. The busy, somewhat disturbed student nurse grabbed my hand and forced me to hold a piece of cotton over the wound until it stopped bleeding.

Again, most of my time was spent watching and listening. When possible to do so unobtrusively, I took almost literal notes in a small book which was carried between the covers of a medical history folder. I tried to capture as complete a "transcript" of the on-going talk and behavior as possible, excluding only minor technical remarks such as, "pass me the sponge." Most of my information is based on these observations and on casual conversations I had with members of the staff and patients. While being aware that my presence in these areas may influence the staff's talk and behavior, I felt that
this effect was probably mitigated to a significant extent by the long periods of time I spent in their presence, as well as by the fact that in the clinic and delivery room staff usually were under a good deal of pressure to perform their tasks as quickly as possible, presumably making it more difficult to alter their performances for my benefit.

**Access**

While I experienced few problems in gaining and maintaining access in the clinic, the delivery floor was found to be more difficult. In this section I would like to try to account for this difference in accessibility for the two-fold purpose of not only describing some of the features of gaining access to a "difficult setting," such as this one, but also to reveal features of the social organization of the hospital, particularly those that impinged on the collection of data. Also, while rarely reported by ethnographers, this kind of background information would seem to be of central concern in determining what is being reported. In other words, these access problems (or the lack of them in some areas of the hospital) must be seen as part of the data collected and taken into account in any analysis of the data. Finally, as the reader will see, these problems are not ones that can be solved with more extensive sampling or quantification.

The difficulties experienced in access in the delivery floor had their origin when a high-level administrative nurse gave me permission to begin observing activity on that floor.
At that time she admonished me not to talk to nurses on that floor because "they are too busy." "After all, you're here to study the patients and their treatment and not the nurses."

Then she said she was worried that I, a lay outsider, should be allowed to witness events in the delivery room at all. I tried to reassure her that I was simply going to record literally what took place in that area. However, apparently she was still not convinced of my objectivity and competency as an observer:

   But you aren't a medical person. So, you won't understand what's really going on. A lot of things go on in the delivery room only the medical staff really understand. You won't know how to correctly interpret the real meaning of what goes on up there.

At this point she said she was very busy and terminated the appointment I had with her.

During my subsequent observations in the delivery room I tried to follow her instructions about not talking to nurses. I did so by confining my interaction as much as possible to doctors, interns and medical students. However, in the close confines of the delivery rooms the barrier I tried to erect between myself and the nurses began to break down. There the assistant head nurse took the initiative by asking about my research. Because she had the task of supervising other nurses during the delivery she was often free from the on-going activity to talk to me. Within the close quarters of the delivery room we occasionally found ourselves the only "spectators" in the delivery activity. As a result, I felt some pressure (and presumably she did, too) to establish a conversation. As it turned out, she had attended some classes in sociology and
anthropology. Apparently for this reason she was eager to learn from me how I as a researcher perceived the delivery activity. Also, she would often proffer information on the nurses' routines in the supervision of patients in labor and the social science literature dealing with staff-patient relationships. Next, other nurses began initiating conversations with me about what I was recording in my note pad and their own views about the floor's organization and routines. They appeared to be curious about the activities of a relative "stranger" in their midst. Once they ascertained my specific purpose for being there they often tried to "help" me by offering bits of "gossip" about the floor's activities. Nevertheless, I still tried to avoid initiating conversations with the nurses. However, given the close quarters of the delivery rooms and central hallway (see diagram of the floor plan, page 59) and the fact that they had learned my name (and I, theirs) it became increasingly difficult to keep my interactions with them to a minimum. During this time, however, the Head Nurse of the floor (in charge of administrative tasks), who had already been apprised of my role in the hospital, remained aloof and cool to my presence on the floor. She did not try to initiate interaction with me.

When the period of my observation on the delivery floor was about half over the high-level administrative nurse had me called into her office. There she admonished me that I was not to "talk to the nurses so much." "You're supposed to be studying the patients' relationships with staff--not the staff."
agreed to continue to try to follow her instructions.

However, following this warning, the floor Head Nurse was occasionally absent for several days at a time. During her absences the assistant nurse (and others) became more aggressive in their attempts to "help" me by offering me bits of "gossip." On one such occasion they discussed with me a caesarian section where the baby almost died at birth. When the Head Nurse returned after this occasion, she notified me that the high-level administrative nurse had told her to tell me that I was not supposed to come up to the delivery floor any more.

When I subsequently discussed with the high-level administrative nurse the reasons for my dismissal she told me that the patients' privacy has to be protected and that the nurses had complained about my presence in the delivery room. Plus, she said,

We don't gossip about patients, especially when they are Hospital staff. The patient whose baby had problems in the c-section was staff. But you are not to think of it as being dismissed at all. It's just that we think you must have enough by now to get an overall picture of the delivery floor. That's all we agreed to in the first place.

(In fact, we had never discussed the length of my observations on that floor.) Because I felt I had enough observations for an adequate description of the delivery floor, and due to my frosty reception from the Head Nurse, I did not try to renegotiate access to that floor.

Later, when I discussed with the delivery floor nurses the reasons given to me for being dismissed and being limited as
to whom I could talk to on the floor, they said that they had not heard any complaints about my presence from members of the nursing staff. On the other hand, they suggested that the "real reason" for the limitation and ultimate dismissal was that the nursing administrators (including the Head Nurse of the delivery floor) were concerned at that time with the fact that the Hospital was undergoing a review of its efficiency and budget by the Hospital's trustees. In fact, they informed me that just two weeks prior to my initial appearance in the delivery floor a "time and motion" efficiency "expert" had been taking notes while "shadowing" staff members, much as I had done. The interns who were on duty also gave me this theory when I discussed with them the reasons for my dismissal. Further, these staff members' theory that the administrators were primarily concerned with the on-going "efficiency review" appeared to be supported to some extent by the fact that several months after my dismissal the principal newspapers of the city reported that a number of nurses had been discharged from City Hospital as a result of the "efficiency review."

One way to understand the negative reactions of the high level administrative nurse to my presence in the delivery floor is to make use of the notion that members of society in their interaction with other members employ categorization devices and associated expectations about behavior in order to make sense of the situation and to guide their own actions in the exchange.\(^{25}\) When people who do not know each other are placed in a position of interacting, we might assume that they
are going to try and find out what the other wants or is doing. It may be that one way of checking on who a person is and what he wants is to make use of information already at hand about people who seem to be like him. If the person does not belong to a category that the other possesses information about and he has to handle what he sees as potentially dangerous information, interaction may be both problematic and stressful. The observer is present by design to find out what is going on and the administrative staff may want to limit what it is he hears and sees. These staff members may be concerned not to make information available to the observer that later can be used against them.²⁶

What I am arguing is that the reason that some of the administrative nursing staff did not seem happy about my presence is due to the fact that they were not sure about the "real" purpose of the research and their problem of finding out what was the real purpose was predicated on associating me with a category of persons about whom they "knew" something. One way of solving the problem would be to see if I could be assimilated to any of the social types who are "normally" around the Hospital. For example, in the clinic the administrative staff also were not sure how to regard a sociologist being in the hospital. Apparently they saw me as making some kind of study they did not understand. However, a year before my appearance in the clinic a fourth-year medical student had done a study there of unwed mothers' psychological reactions to
pregnancy. In so doing he was aided by the social worker, who interviewed the unwed mothers who came to the clinic for prenatal care. I believe as a result of this past experience with the presence of a person doing behavioral research (an experience which was lacking in the delivery floor), the social worker quickly "took me under her wing" and other staff members assumed that I was in some way affiliated with her. Thus, I believe that the availability of the category of "behavioral researcher" to typify or assimilate the otherwise enigmatic title of sociologist greatly facilitated access to the clinic. On the other hand, the nursing administrator's apparent use of the category "critical lay observer" (perhaps even some kind of "efficiency expert") who, as she puts it, "... won't know how to correctly interpret the real meaning of events..." to resolve the problem of making sense of a puzzling researcher who wants to "shadow" staff members during a period of budgetary and efficiency review probably contributed to my access problems in the delivery floor.

Other ethnographic studies of obstetrical and/or gynecological services appear to support my view of the importance of categorization of the researcher by staff during the conduct of field work. For example, William Rosengren found that the lack of clearly defined categorization by staff presented an obstacle to doing his field study.

... During the first two or three evenings, the most pronounced obstacle to both accurate observation and acceptance by the personnel was the fact that from their point of view we had neither legitimate status nor meaningful roles in the hospital. Simply, people wondered what we
were doing there and how they should relate themselves to us. Initially, many of the personnel—particularly the staff nurses—seemed to think that we were new externs (medical students). And perhaps because of this we were occasionally called upon by the nurses to assist in a subordinate fashion with some of the minor tasks preparatory to delivery. Others seemed to feel that we were "inspectors" from the National Institute of Neurological Diseases and Blindness. For ourselves, we remained mum on the issue. The first definition of us by the staff gave us meaningful roles but no status. The second gave us legitimate status but no meaningful role. As observers, therefore, we were caught up in an almost ideal contradiction of status and role. The dilemma was gradually resolved: First we were given a kind of status, primarily by being allowed to observe high-status private obstetricians and their patients. We were then provided with a meaningful role, from the point of view of the obstetrical team, by helping them with some of the observations and recordings required by the National Collaborative Study (of Birth Defects—J.E.F.) which the team members found burdensome to do themselves.27

Joan Emerson in her study of gynecological examinations in a medical school also found that being categorizable by staff as having a (as Rosengren terms it) "meaningful role" vis a vis life-as-usual in the hospital greatly enhanced her ability to gain information. Like Rosengren, she found that a more participant role (acting as a nurses' aide) increased her acceptance by staff members. Possibly if I, too, had had some familiar "meaningful role" whereby staff (but especially the administrative nurses) found me a positive aid in their everyday work routines, then the ambiguity of my research activity may have been overlooked in favor of my "contribution" to easing the work load in the delivery floor.

However, I suspect that the problems I encountered with participating in "gossip" may have been much more difficult to solve or prevent. For example, like myself, Emerson found that
refusing to join in the "gossiping" among staff members resulted in a "barrier" to gaining rapport and acceptance.

... At the onset of the research the observer had the policy of not giving information or opinions about any subject (staff, patient or visitor) to any other subject, unless it were a matter of carrying messages or something which came up in the observer's role as nurses' aide. The barriers created by the observer's refusal to contribute "gossip" about patients (and visitors) seemed formidable enough to suggest that such a policy was too rigid when the observer was a participant to the degree that she was, and by the time the observer arrived on the medical ward she participated circumspectly in the gossip (and occasionally "technical reports") about patients.

Recording Observations

In attempting to take almost verbatim notes I tried to position myself in the three areas so that this recording activity would not become a focus of attention for subjects being observed and thereby disrupt the normal on-going interaction.

In the clinic waiting room the benches where waiting patients sat usually were fairly crowded with patients and their male companions. I usually sat at the end of the waiting bench next to the wall on the side of the bench next to the Social Worker's "office" (see the floor diagram at the beginning of Chapter II, page 58) to take advantage of this crowd to reduce the visibility of my presence and note-taking activity. As a result, usually the waiting patients and their companions did not seem to take particular notice of my presence and rapid recording of staff-patient interactions.

In the pelvic examination area of the clinic I wore a white coat while accompanying five or six third-year medical
students and a teaching resident or obstetrician when the medical history, general physical examination and the pelvic examination are performed. During this period of contact with the patient, a student normally records in detail the patient's history and notes her blood pressure and other observations derived from the physical and pelvic examinations. As a result, my own recording activity for the most part went unnoticed by all participants.

Similarly, from the time patient enters the delivery floor, staff (usually the nurses) occasionally record their observations of the patient's progress in labor. In fact, in a corner of the delivery room at the head of the delivery table is located a small writing shelf, where they periodically record observations on labor progress and the delivery process. (See diagram of delivery floor at the beginning of Chapter II, page 59.) During my observations I stationed myself at that recording shelf, where I was fairly well removed from staff members' work. Usually my note-taking seemed to go unnoticed by staff, particularly when they were busily engaged in labor coaching and in the delivery process. However, when there was a break in the activity, occasionally a nurse would ask what I was so busy recording. I would then show her my notes and a discussion of my research would ensue.

Generally, I tried to avoid taking notes in the hallways of the areas because there it seemed to attract attention from staff members (not so, patients). It provoked their inquiries as to my credentials for being there (as a possible
"newspaper man") by those staff members who had not been introduced to me. Thus, when I observed staff-patient or staff-staff interaction in the hallways I had to duck into an unoccupied examination cubicle, a lab room, the doctor's lounge (if it were unoccupied), or the lavatory to record my observations. Consequently, before my observations in the hospital were complete, I had identified various niches in the ecology of the clinic and delivery room floors which would provide at least a temporary barrier behind which I could retreat to take notes.

In conclusion, the methodological problems I encountered in trying to capture a complete picture of work routines without the aid of a tape recorder or videotape machine are informative of not only how to do such an ethnography, but also the social and ecological organization of the hospital vis a vis writing and note-taking by staff members as a normal, life-as-usual, located activity.

The quotations that appear in this thesis to illustrate features of staff members' work routines in the hospital come directly from my field notes. The only alterations made to the original notes involve their grammatical structure. Specifically, in some cases I was so busy trying to record what I was observing that I neglected to provide clear sentence and paragraph breaks in the original field notes.

As additional sources of data for this thesis, I will draw on published and unpublished descriptions of labor and delivery room interaction by patients who have tried to deliver their babies without anesthesia, i.e., what are loosely typified
by staff as "natural childbirth" patients. Most of the groups and organizations that provide training to prepare these patients usually require a "birth report" from each woman to assess how successful they were at doing without anesthesia, as well as to learn various hospital's treatment routines and how to cope with them, if necessary. Approximately 120 reports from patients in the East and Western United States and England were analyzed to discover what management techniques were employed in various hospitals. In most cases the methods I observed at City were also described by the reports of the "natural childbirth" patients. Thus, descriptions from these reports will be used as a source of corroborating or supporting data.

An additional source of supporting data were found in the non-fiction published accounts of experienced private obstetricians. Since they are written for a non-professional audience, they provide clear, detailed descriptions of actual interaction between doctors and patients in the private offices where medical interviews are conducted and pelvic and physical examinations performed, as well as in labor and delivery rooms.

Finally, I would like to conclude this section by expressing my gratitude for the cooperation extended to me by the staff members and administrators at City Hospital in allowing me to accompany them in their routine activities and answering my naive questions. In accord with promises I made to them, unfortunately, I am unable to thank individuals by name or identify the institution directly. For the same reasons of
confidentiality and anonymity, the names of staff members and patients have been changed or deleted from the reported observations.

Organization of the Thesis

The thesis is organized so as to give a detailed analysis of the three areas in City Hospital where I found the most sustained interaction between staff members and patients. Thus, each of three chapters analyzes the organization of the staff members' work routines, particularly patient management techniques, for a particular area. Analysis of the areas will be presented in the same order as they are encountered by the "typical" obstetrical patient as she progresses through each stage of her organizational career: first the work routine in the Clinic waiting room or intake area (Chapter III), then the cubicle or pelvic examination area (Chapter IV), and finally the organization of work routines in the delivery room (Chapter V).

Before presenting these three chapters, I will, in Chapter II, provide the reader with a brief run-through of the routines in the three areas to give a general overview of the staff treatment practices that will be dealt with in subsequent chapters. Also, in the second half of Chapter II, I will begin to provide some analysis of intake area work routines by showing how the organization of staff's work influences the "organization of embarrassment" for the patients, i.e., how the pressures of processing a large patient case load in a short
time leads to "neglect" by staff of ideologically prescribed proprietous treatment of patients, many of whom are unwed and concerned to manage the visibility of their stigmatized status (unless, of course, such proprietous "protective" routines are costless of time, energy, etc.).

In Chapter III, I will describe other patient management routines in the intake area (and to a lesser extent those in the cubicle area) and staff's view of themselves as having a mandate to instruct and to lay the whole routine of pre-natal care on patients, regardless of their situations and views. Many patients' reactions to staff's treatment here and in other areas can index their character as "troublesome" from the staff's viewpoint. In other words, in this Chapter, I will try to show that there are systematic attempts to coerce patients to "shape up" so that in the always-oriented-to final stages (labor and delivery), they will (hopefully) be "good patients."

Also, we will see staff protecting standardized routines—e.g., requests for a female doctor get treated as organizationally disruptive. In this Chapter, too, I will attempt to show how the social worker in the Clinic is occupationally trained, as part of the (medical) "team," to look ahead to the baby's "fate" after birth--issues of father's employment, adoption, etc. Here, and with doctors in the cubicle area too, the medical shades off into concerns with "model middle-class family arrangements," and staff in both areas seem to treat their mandate to enforce these for granted.

Chapter IV deals with patient management techniques I
found in the cubicle area where pelvic examinations, general prenatal physical examinations, and prenatal lectures are given to obstetrical patients. Here, I will try to demonstrate how work exigencies such as work scheduling and providing a visibly competent performance result in only the occasional implementation of the ideals of the medical ideology (including the "necessity" to "teach" patients, treat their "individual" problems, and give proprietous care) in regard to patient management techniques; an approach to patient "care" and the teaching of students I term the "technical approach" (as opposed to the academically-located "patient as person" medical philosophy or approach which supports the more consistent implementation of ideological ideals in everyday work routines). Since medical students do the bulk of the work in this area, I will pay particular attention to analyzing their organizational problems, work orientations, concerns with "getting through" prenatal interviews and general examinations in a visibly competent manner, etc. Some of the supervisory contact is oriented to "making physicians" of medical students. In this process, supervising physicians may give "pep-talks" containing ideal "ideological" components on the "patient as person" approach, as I have termed it, but seem largely to ignore students' practical work problems. In other words, in these didactic sessions, the "technical approach" (the medical philosophy, generally of an implicit nature, which is most commonly followed by Residents and medical students in the cubicle area and delivery room, as well as by staff in the
intake area) to patient management may be down-graded as a medical philosophy, but students have to come to terms with the demand characteristics of the situation (scheduled work and visible competence) once they get to the cubicles.

Chapter V documents the intransigence of labor and delivery as "raw materials" for organizational programming and the patient management work routines developed to cope with the naturally difficult features of these processes in terms of the demand characteristics of scheduling them as work and providing a visibly competent performance while "aiding" these processes. Also, I will try to show in this Chapter how the ethnographic method adopted for use in my research is particularly useful for revealing features of work routines, including management techniques and the "problems" or "complications" they cause obstetrical patients in labor and delivery. The efficacy of this research strategy will be contrasted with a structural survey approach to theory and method which imposes the researcher's organizationally alien view of events in the hospital as resulting from extra-hospital attributes and processes of staff and patients (e.g., social class, social psychological attitudes, beliefs, etc.) and thereby often produce demonstrably spurious analysis of such organizational events as labor and delivery.
FOOTNOTES


... I have attempted to represent the variety of research concerns and strategies which today pass as ethnomethodology. The subsuming of these works under that rubric is my responsibility, and I have been
guided chiefly by practical professional criteria:
I think it is safe to say that all of these authors
would be regarded by "traditional" sociology-itself
a gloss for a set of diverse enterprises—as practi-
tioners of the "school"... In short, what ethno-
methodology now amounts to is to be located in the
research output of its practitioners...

Turner subsumes the works of the following sociologists
(among others) under the rubric of ethnomethodology: H.
Garfinkel, Dorothy Smith, Egon Bittner, A. V. Cicourel,
David Sudnow, Don H. Zimmerman, Roy Turner, and Harvey
Sacks.

16. Ibid.
17. Ibid., pp. 16-18.
18. Zimmerman, "Tasks and Troubles: The Practical Bases of
Work Activities in a Public Assistance Organization,"
19. David Sudnow, "Normal Crimes: Sociological Features of
the Penal Code in a Public Defender's Office," Social
Problems, XII, 1965.
21. This publication was a small pamphlet, "The City Hospital
Story," readily available in the waiting rooms and
reception areas of the Hospital. From this document I
drew the statistics which I produce in this section.
22. Ibid.
25. This formulation is based loosely on Harvey Sacks' formu-
lation as found in his unpublished doctoral disserta-
tion: "The Search for Help: No One to Turn To," University
of California, Berkeley, 1966.
26. This situation may be seen as having properties similar
to those reported by Orne, Mills and Reicken with regard
to small group research. They report that subjects do not
play a passive role in research but bring into play the
same social skills they do in other situations. Clearly
this also applies to field as well as experimental
research. Orne, "On the Social Psychology of the
Psychological Experiment; Thdodore M. Mills, "A Sleeper
Variable in Small Groups Research: The Experimenter,"
Pacific Sociological Review, (Spring, 1962), pp. 21-28;


30. The following are some of the "Birth Report Guidelines" for "natural childbirth" patients to follow in describing for the natural childbirth organization their experiences in giving birth in hospitals. (Taken from p. 18 of Mary Kay Woodward. The Lamaze Method of Childbirth Education Student Manual (Fontana, California: Preparing Expectant Parents, 1970).

BIRTH REPORT GUIDELINES

PLEASE--do it as soon as possible, in the hospital, so it doesn't get shunted off with the "sometime" things when memory may be less vivid and accurate.

This needn't be what you'd consider a "Literary Masterpiece"--just your own account of what happened--as clear, concise, and complete as possible. The true value of a birth report rests in the telling of one very special "Birthday Story" by those who made it so. (Husband's comments encouraged and greatly appreciated.)

Please try to give a little background concerning your becoming interested in childbirth preparation . . . including comments of previous experiences in childbirth. Follow as well as you can and feel to be helpful: your progress through labor; mentioning difficult and easy parts (when and how long; 1st phase, 2nd or "Working Labor" transition, expulsion--about how many contractions, pushes, etc...episiotomy?) Tell of adaptation needed (when to use which breathing), feelings then, other points which most impressed you, and might help someone in a similar situation to better analyze her needs.

Spotlight afterthoughts: yours, husband's, doctor's, hospital staff's (Try to get names of those particularly helpful, understanding, and/or interested so that you can drop a note of appreciation later.) How do you feel about recommending this approach to others? Please include a
line granting us permission to publish and/or quote any or all of your report, and sign it.


CHAPTER II

WORK ROUTINES AND EMBARRASSMENT

This chapter will first provide a brief run-through of the work routines in the three areas of the hospital where I found the most sustained staff-patient interaction. The intent is to give the reader a general overview of staff treatment routines that will be dealt with in subsequent chapters. In the second half of this chapter, I will begin the analysis of intake area work routines (which will be continued to completion in Chapter III) by showing how work exigencies allow only the occasional implementation of ideologically prescribed ideals of proprietous treatment of patients. The second half of this chapter, then, initiates the analysis of the effect of the practical features of work routines on the implementation of professional ideals of patient care. This latter analysis will be particularly carried through in Chapter IV (the cubicle area) and Chapter V (the labor and delivery areas).

Overview of Routines

The Outpatient Clinic of City Hospital provides gynecological, prenatal, and "well-baby" care, as well as social service primarily to those who do not have or cannot afford a private physician. Members of the staff typified the
patients who use the clinic to consist of unwed girls from the Home for unwed mothers, Indians from tribes in Western Canada, women whose husbands had deserted them or were unemployed or in jail, women from prisons and juvenile halls, prostitutes, "go-go girls," mostly unwed young "hippies," and a few students. For the purposes of providing some ethnographic background on the intake and cubicle areas I would like to follow the "typical" or "routine obstetrical patient" through her initial check-up routine in the clinic. Most of the prospective patients were required to make an appointment for one of the weekdays on which the obstetrical clinics are offered: Monday, Wednesday, or Friday from 12:45 to 4:00 in the afternoon. All patients are given a 12:45 appointment to allow time to process them before 2:00 when the residents and students arrive to interview and examine the patients. After the patient arrives, the receptionist or the head nurse requests that she go to the "ladies" to "empty her bladder" and "leave a specimen." Then, since most patients do not have provincial or private medical insurance, or sufficient income, the receptionist sends her to the office of the "eligibility social worker" (see diagram on page 58) who helps them fill out an eligibility statement to determine if she qualifies for provincial aid to pay for her prenatal check-ups, medication, and delivery of the baby by a "clinic" or "staff" resident or intern. This completed form is given to the social worker who makes the final assessment of eligibility and advises patients on employment, housing, family and psychiatric problems, as well as
referral to an adoption agency or psychiatry outpatient department, if necessary. After being interviewed by the social worker in her office, the patient is weighed and has a blood sample taken by the head nurse. Finally the head nurse calls her name from her file and a practical nurse shows her to a cubicle and instructs her to undress and dress in the gown. She usually sits on the examining table for fifteen to twenty minutes before the medical student or resident appears through the curtains. Typically, he does not introduce himself and hurriedly asks her a series of questions on her and her family's past medical problems, as well as the history of her menstruation, any past pregnancies, and her frequency of sexual intercourse, and birth control practices. He then gives her a cursory, general physical examination. The nurse "puts her up" by placing her legs apart resting on boards or "stirrups," exposing the pelvic area. He performs the pelvic examination to check for uterine cancer, infections, venereal disease, symptoms of pregnancy, and the dimensions of the pelvic arch relative to the probable size of a baby at "term." Then the patient is told to get dressed. After she is dressed, the resident or student usually tells her she is in good health and whether or not he thinks she is pregnant. He writes her prescriptions for vitamins and irons and instructs her to return in a month for a routine check-up. She returns to the receptionist's counter for another appointment. Usually, the receptionist refers her to the dietitian's office
for dietary advice or to psychiatry outpatient if the doctor recommends it.¹

On the "term" or probable last prenatal check-up before delivery, another pelvic examination is performed to check on the progress and disposition of the baby. At the conclusion of this visit the patient is told to call the hospital and come in when her labor contractions are five minutes apart. A large proportion, perhaps a majority, of the patients who deliver at City are "private." However, all patients who arrive in labor have their genital area shaved, given an enema, and a pelvic examination by an intern to determine whether her labor is "false" (in which case she is sent home) or "real" (in which case she is sent up to the fourth floor).² Her husband, if he is not to be present in the delivery room, is sent up to the waiting room on the third floor. On the third floor are twenty to thirty private and semi-private rooms for obstetric patients (usually recovering from delivery) as well as gynecology patients. The second floor consists of two open wards of fifty beds each, as well as a glass enclosed nursery for newborn babies. If her cervix has been diagnosed as being less than ten centimeters dilated, she is put in one of the four labor rooms on the delivery floor (see diagram on page 59 ). Her progress in labor is monitored by nurses on the floor who call her doctor when her cervix has reached eight to ten centimeters
and diagnosed ready for one of the three delivery rooms down the hall from the labor rooms. She is usually entering the "pushing" or second stage of labor when put on the delivery table, legs and abdomen draped with sterile sheets, and legs spread and strapped on stirrups in the same position she assumed for a pelvic examination. Meanwhile, her doctor usually has arrived from his office or another part of the hospital. Depending on her progress, he may check in with her first or go directly to the doctor's lounge on the fourth floor where he changes into a green sterile gown. He then proceeds to the delivery room where an anesthetist has probably already begun giving the patient, who often is in pain and loudly complaining, doses of nitrous oxide through a mask. While she was in the labor room the senior nurse on duty may supervise the administration of heroin (City is one of the few hospitals left with a supply of this pain-killer) or other anesthetic. If the delivery and baby are expected to be routine and trouble-free, the doctor is usually assisted by the intern, an anesthetist, and four nurses, two of which are students. If the husband is allowed to attend the delivery he is firmly told to stay at the head of the delivery table and not get in the staff's way. The resident pediatrician and his assistant (or a private specialist) usually are present with emergency resuscitation equipment for an expected troublesome delivery or baby, such as in cases of premature and Rh negative babies or a tight pelvic arch. The members of the "delivery team" all
take part in shouting instructions to the patient on how to push "effectively," as well as "encouragement" to sustain her pushing until the baby is delivered. During this second stage of labor, the doctor administers a local anesthetic and cuts an epesiotomy to increase the size of the vaginal opening so the mother will not be "torn" when she finally expells the baby. When the baby is fully expelled, the doctor announces its birth by loudly and excitedly telling the patient its sex. Often he will also praise its health and attractiveness. The naked newborn baby is often immediately held up for the patient to see. The baby is then given a cursory physical examination by the senior nurse present, while the doctor has the patient expell the placenta and sews up the epesiotomy. When the nurse completes her examination of the baby she attaches a name tag to its wrist and wraps it in a blue or pink blanket, depending on its sex. She then usually presents it to the patient, placing it on a tray next to her so she can see it or give it to her to hold, depending on the patient's condition after delivery. As with the doctor's birth announcement, she and the other nurses then proceed to praise the baby's appearance and health and try to get the mother to do the same. If the patient is unwed and plans to give it up for adoption (usually a "clinic" patient) the doctor does not usually praise it when it arrives, merely announcing its sex. In a similar fashion, the nurses do not usually hand this patient her baby or place it on a tray, but ask first if she wants to see the
baby. If the patient responds negatively, the baby is quickly taken away after being examined and wrapped. If the patient wishes to see or hold it the nurses refrain from praising or otherwise discussing the baby while she is holding it. After he finishes sewing up the episiotomy the doctor again congratulates the patient and praises the baby (if the patient is keeping it) before leaving to break the good news to the husband if he has not been present for the delivery. If the doctor is busy he may not go down personally to the third floor but instead phone the head nurse on the third floor and have her inform the husband. With regard to complications and a biologically troublesome baby ("bad news"), the doctor makes a point of personally informing the husband. If the husband is at work or at home the doctor usually tries to contact him by phone soon after the delivery. In most cases where the delivery has been routine and trouble-free, the announcement to the husband is brief, something like, "Congratulations! It's a boy! Your wife and baby are fine. Ok?" Meanwhile the patient is left alone in the delivery room for an hour after the delivery for "observation" before being wheeled on a stretcher to one of the "recovery" beds on the second or third floors. She is usually kept in the hospital for three days afterwards while her doctor or the resident on duty checks the healing of the episiotomy and her general recovery.
The Organization of Embarrassment

While our "typical" patient was in the intake area prior to being examined, staff's interaction with her characteristically displayed a pattern of non-privacy and non-confidentiality. Typically, researchers have attributed this sort of treatment to the staff's beliefs and attitudes concerning the moral and economic "inferiority" of the average "clinic" patient. In other words, it has been asserted that because staff regard them as "poor specimens of humanity," they are "callous" and "careless" in their treatment of them as opposed to middle class "private" patients.

While these beliefs may exist at City, I suggest that organizational features such as the ecology of the clinic waiting room and the pressures of a large case load to be "processed" in a short time probably are of equal or greater importance in influencing the staff's treatment of the "clinic" patient. For example, on a "full clinic" day when most of the patients keep their appointments, the head nurse remains standing behind the table by the scales where the patients' files are stacked. She seldom moves from that location when there are a lot of patients to be processed because from there she can easily look at one file then another and summon patients to be weighed and have their blood taken. However, this physical arrangement requires that she speak loudly or shout to the patients waiting on the bench and to the receptionist behind the counter. Also another important ecological feature
is the close proximity of the benches on which the patients wait to the reception counter. This placement enables waiting patients to overhear most conversation at the counter unless the participants speak very quietly. Now I would like to describe this pattern of interaction more specifically. When the nurse is in a hurry, she calls a patient's name loudly, and before she closely approaches the table she will loudly tell her to "take off your shoes, you're going to be weighed." When she announces the weight she does so loudly so the receptionist can record it in her file at the counter. The nurse will also fairly loudly praise or condemn the patient for a weight loss or gain. In reacting to this, the patient will look and blush after a quick glance at the waiting area to see if anyone has taken notice of the nurse's announcement. Also, the head nurse will loudly call a name, and before the patient can get closer than ten feet to the table will loudly instruct her to "go empty your bladder and leave a specimen," or "go to the washroom and piss in a paper cup." Patients often appear embarrassed at this instruction and glance at the bench "audience" before going into the "ladies." Apparently the head nurse is concerned to have them quickly get in and get out of the lavatory so she can send another patient to leave a specimen. With regard to taking blood samples, the nurse will call out a name and as soon as a patient begins to approach her table she starts quickly walking back toward the "blood office," yelling to the patient hurrying to catch up something like "Come, I want to take your blood!" Often
Fig. 2.—Fourth Floor, Obstetrics and Gynecology Building
Delivery and Labor Floor
patients, especially if it is their first visit, will suddenly stop and reply with alarm, "Blood!", before continuing after her. Finally, after a patient has been examined, the head nurse checks the doctor's instructions in her file to see if she should see the dietitian or the psychiatrist. Again, she will issue instructions loudly before the patient reaches her table: "You're overweight! See the Dietitian!"; or, "You need to see the psychiatrist! Go to O.P.D.!" (the outpatient department for psychiatry).

The receptionist, although her counter is next to the benches, must ask "personal questions" about patients' finances to see if they should be referred to the "eligibility social worker's" office. If she is in a hurry to get another patient into that office she may just ask while a patient is seated if she is on welfare or has medical insurance without first summoning her to the counter and shortening the distance between them:

R.: (loudly) "Do you have medical insurance?"
P.: "No."
R.: "Are you working?"
P.: "No."
R.: "Is your husband working?"
P.: "No."
R.: "See Mrs. Brown, then."

Also, the receptionist must, in making an appointment for a patient, request the reason for it so she will ask the patient what her problem is before giving her an appointment.
R.: "Do you have an appointment?"

P.: "No."

R.: "You will have to make one. What's your problem?"

P.: (very quietly but still easily overheard): "I think I have V.D." (she bows her head and giggles and then glances nervously at the people sitting at the bench who are staring at her)

The receptionist must ask questions of the head nurse about patients who have just left the clinic or may still be in the waiting area. If she is in a hurry, she will do so at a distance from behind her counter. Also included in these exchanges are what normally would be considered "back stage" talk deriding or criticizing patients.

R.: "Miss Brown has called Dr. Johns (an administrator)."

Nurse: "Miss Brown is a staff patient and was told to call me, not Dr. Johns. So have her call me. She is a nuisance! She's a nuisance!"

The social worker also will try to gather information about patients from the receptionist or the head nurse while they are being examined or after they have left. If she is pressed for time, she may yell questions to them across the crowded bench area.

S.W.: "Is April ok?"

R.: "She just left."

S.W.: "Is her head all right?" (This patient had a head injury.)

R.: "She said she was going to the head shrinker! Ha! Ha!"

The residents and students who do the examinations are
also usually quite busy. So, when a patient leaves the cubicle
without waiting to get the post-examination advice, the doctor
will come out to where she is sitting in the waiting area to
advise her, rather than take the time to take the patient back
to a cubicle, which is often filled immediately after a patient
leaves, in any event.

Dr.: "You've gained a lot of weight. That's bad!
You better get some 'water pills' and iron.
Watch that infection and tell your boy friend
about those symptoms."

The patient, who is sitting at a crowded bench, frowns and
looks down at the floor.

Patients usually try to manage the lack of privacy and
confidentiality by coming close to staff before speaking (e. g.)
about why they came to the clinic or to tell the head nurse
that they cannot "go to the bathroom" when they are requested
to do so. Often they then mumble or speak very quietly,
glancing around them and back to the people at the bench.
Also, when a doctor or nurse is discussing their cases with
them at the bench or counter, the patients will try not to
reply to questions or volunteer comments. When the reception­
ist or head nurse asked them questions from a distance, the
patients will not verbally respond, and instead gesture a
"yes" or "no."

Nurse: "Are you to be examined today?"
P.: (sitting at the bench, shakes her head up and down)
Nurse: "Have you been in there?" (Patient shakes her
head "yes.")
When the nurse made this last utterance, she pointed in the direction of the lavatory and kept moving her index finger up to her forehead as if to scratch it. Thus, she tried to mask her pointing gesture so as to appear as not to be indicating the lavatory. Here is one of the instances where the head nurse used a verbal indirect reference and a "gestural locator" to the "ladies." They show that she was aware of the proprieties surrounding speaking about elimination in public. Instances of this sort of circumspection usually occurred when she and the rest of the staff were not "too busy" and could look up from their records and files to establish face-to-face contact with a patient across the waiting room. In a similar fashion, when not busy she would quietly tell a patient her weight and walk over to the receptionist's desk to quietly inform her, instead of loudly calling out the weight. Also, she would then take time to wait until the patient reached her before accompanying her back to the "blood office."

Many of the clinic's obstetric patients were unwed and apparently found the public character of the waiting room problematic in terms of managing their appearance to conceal information or signs of their "flawed" character. I take it that generally as visual evidence of pregnancy appears in the form of a swollen abdomen, many unwed women feel that they face an increasingly difficult task of reducing or concealing information about their unwed status which would render the increasingly visible bulge stigmatizing. Apparently, these women
assume the primary part of their personal front that a public audience attends to in deciding marital status, is the third finger of the left hand where wedding rings are customarily worn. One method, therefore, for dealing with the assumed scrutiny of this area is to wear a wedding band, or other type of ring, on that finger in order to "pass" in public places as a wed pregnant woman. In fact, evidence that unwed pregnant women regarded the clinic waiting room like other public settings requiring "reputational work" or "stigma management" was found by the fact many of them wore such "passing devices." They seemed generally willing to inform staff of their "real" status in "backstage" areas such as the social worker's office and the dietitian's office, while making efforts to conceal evidence of it in the more public waiting area. Apparently this device was somewhat successful because in the waiting area even some of the staff members assumed from the ring that the patient was wed, although once in the "backstage" areas, often the patient would correct this impression. The staff members who were most frequently "taken in" were new and inexperienced. They found these "mistaken" categorizations to be sources of irritation and embarrassment. One type of staff member, the dietitian, more commonly made these faux pas because she usually spent only several weeks in the clinic before moving to another department in the hospital for further training. The following instance was related to me by a dietitian who found this "mistake" to be a source of
annoyance and irritation.

You can't tell by the ring if she's married. This afternoon I made the mistake of calling the father (of the child) husband. This didn't disturb her though—she's only eighteen and immature—she's playing house. She's going to get married in a month. Talks about the father, who she's living with, all the time—Bob this! Bob that!

Most of the patients who did not wear rings nevertheless also showed that they were sensitive to the clinic as one of many public places where an audience routinely judges the moral standing of a visibly pregnant woman, in terms of wed versus unwed status. The warrant for this assertion can be found in the fact that among those without rings the majority made some effort to reduce the visibility of a ringless third finger on the left hand, i.e., to observe some sort of "left hand discipline." In other words, rather than make a more permanent appearance alteration, wearing a ring, these women typically engaged in more temporary, or "situation specific," improvised passing activities and devices. Many of these efforts involved simply putting the left hand in a coat pocket and keeping it there while in the waiting area. For example, when required to fill out and sign forms at the receptionist's counter a patient would try to keep her left hand in her pocket while writing and handling papers with her right hand exclusively. However, patients were sometimes chagrined and exclaimed "Oh!" or "Oh my!" when they remembered at the last moment that they were left-handed. In these cases the patient would hurriedly fill out the form and scratch her signature
and quickly jam her left hand back into her pocket. While waiting to be examined these patients typically tried to do everything with their right hand, keeping their left hand in their pocket. This became awkward when trying (e.g.) to put a cigarette in her mouth and light it, or when trying to read a magazine with only one hand. Another common and more easily managed passing device involved constantly wearing gloves while in the waiting area. When a patient was not wearing a coat, or at least one without pockets, or gloves, then she often engaged in a passing activity wherein on entering the area she holds her left hand up to the side of her face away from the bench area as if to scratch or rub her face. In doing this she would keep facing straight ahead, not glancing at the benches. Another technique involved "playing" with her hair with the left hand on the side of her head away from the audience. If the patient is carrying packages, usually she clasped both hands tightly around the objects so the fingers of the right hand overlapped and concealed the fingers of her left hand. When a patient without coat pockets or gloves was standing in front of the counter or getting up and moving around the bench area to get, for example, an ash tray or magazine, she usually tried to keep her left hand in constant motion by doing various activities such as touching the side of her face, scratching the side of her body, and "playing" with her hair. Presumably this activity was intended to prevent the audience from focusing its attention on the ring
finger long enough to detect whether a ring was being worn.

On the other hand, I also observed that patients categorized by staff as "Hippies" and "Indians" usually did not wear a ring or engage in these improvised passing activities. Staff and most patients consistently act as if the entire membership of the audience shared this concern for reputation. The staff evidenced this assumption of a shared orientation to the stigmatized character of unwed pregnancy in their discreet attempts to, in effect, "collabor­ate" with all patients in constructing an image of them as "wed," i. e., although staff presume they know the "truth," they treat all unwed patients as "wed" while in front of the waiting benches. The most visible technique whereby staff presume to help patients "pass" involves the way in which they addressed them when summoning them to be processed and treated. The social worker described this method to me as follows:

I call all women "Mrs." when calling them into the office; even though the women will say they aren't married when they get in the office. It protects them from embarrass­ment.

When no last name is available, the staff use an ambiguous form of address by calling patients by their first names.

Another interesting feature of the waiting room was the dress worn by visibly pregnant women. I observed many patients, particularly the girls from the Home, discuss the unaesthetic character of their appearance and dress while waiting to be examined. These patients tend to discuss their
pregnancy in terms of a "bulge" which was undermining their attempts to dress and appear "attractive" in non-pregnant terms of ideals of slimness and being able to wear short skirts. To manage the aesthetics of their appearance, many wore full-length overcoats even in fair weather and kept them on while in the clinic which served to conceal the "bulge." Also, patients tended to describe other patients' dress in terms of the extent to which it showed a proper amount of "shame" for their "condition," considered disfiguring. Unlike other "primitive" cultures, the dominant perspective in North America on the proprieties of "appearing pregnant" involves rules on displaying the "bulge" too visibly, which is considered both "unaesthetic" and showing no "shame" for one's "condition." These proprieties were in evidence in the staff's and Home patients' annoyed reaction to "Indians" and "Hippies" who often arrived wearing such dress as tight Levis and tee shorts. In one case, a patient, called a "Hippy" by staff, came dressed in hot pants and a tight blouse which displayed a large proportion of her breasts and swollen abdomen. The staff were very disturbed at how this "interfered" with the work of the male repairmen painting the ceiling, so they quickly shunted her to one of the cubicles for a pelvic examination without the usual processing and one and one-half hour wait. This patient provoked the complaint from the social worker that she "didn't know where this generation was heading" and "Some people don't care!" With regard to patients called
"hippies," the social worker explained that these "violations" were a result of "moral breakdown" and "psychological maladjustment." On the other hand, she felt that the "Indians" were just culturally "different and didn't know any better; but each generation is learning." In any event, the above instances illustrate how staff observe and enforce proprieties and conventions with regard to dress and appearance against "deviant" subcultural groups.
1. If the patient has been diagnosed as not being pregnant, she is notified of this fact and she does not return to the clinic. For the patient diagnosed as being pregnant, she is given monthly cursory physical examinations until the last month of her pregnancy, when she receives them weekly. After her initial, more thorough, check-up she does not usually receive another pelvic examination until the probable last prenatal check-up, unless she has some complaints or develops symptoms indicating possible complications in her pregnancy or problems with her health.

2. A common cause for a patient to sometimes come to the hospital several times before finally remaining and giving birth is her mistaking "false," or Braxton-Hicks, contractions for the actual onset of labor. These are intermittent, painless contractions of the uterus toward the end of pregnancy.


CHAPTER III

PREPARING THE PATIENT: THE ORGANIZATION OF
MORAL CONTROL IN THE INTAKE AREA

In this chapter, I will describe other patient management routines in the intake area (and to a lesser extent those in the cubicle area) and staff's view of themselves as having a mandate to instruct and to lay the whole routine of prenatal care on patients, regardless of their situations and views. Many patients' reactions to staff's treatment here and in other areas observed can index their character as "troublesome" from the staff's viewpoint. In other words, in this chapter I will try to show that there are systematic attempts to coerce patients to "shape up" so that in the always-oriented-to final stages, labor and delivery, they will (hopefully) be "good patients." Also, we will see staff protecting standardized routines—e.g., requests for a female doctor get treated as organizationally disruptive. In this chapter, too, I will attempt to show how the social worker in the Clinic is occupationally trained, as part of the medical team, to look ahead to the baby's "fate" after birth—issues of father's employment, adoption, etc. Here, and with doctors in the cubicle area, too, the medical shades off into concerns with "model middle-class family arrangements," and staff in both areas seem to
take their mandate to enforce these for granted.

As I discussed in the Introduction, medical staff see it as their moral responsibility to try to "teach" patients the medical perspective in order to limit infant mortality and reduce the effects of delivery on the newborn child. Likewise, in the intake area, or waiting room, the staff members (social workers, nurses, and receptionist) try to thus manage what they characterize as "ignorant" or "culturally backward" patients, as well as those who adhere to non-medical or folk approaches to prenatal and natal events. Thus, the waiting room becomes fairly frequently a scene of cross-cultural conflict wherein staff members make it their business to try to "resocialize" or "teach" patients (regardless of their situations and views) their "responsibilities" toward the unborn child vis a vis medically prescribed routines of prenatal care and delivery.

For example, the social worker related to me the following "incident" which illustrates staff's strong moral reaction and coercive approach to patients who insist on using "non-medical" techniques.

Yesterday a hippy, from Midwest Province, and his wife, from New York, (I suspect her parents are sending her money) came in with a baby delivered by the father. He was dirty, filthy, long-haired, and smelled. The poor child. Disgusting! It had had no medical treatment so the baby's eyes swelled up and the skin was peeling. Otherwise, it was thriving. They came because they needed a doctor's signature to get the Department of Statistics to register the birth. When (the head nurse) tried to feed the baby glucose formula, the mother knocked it out of her hand--"The baby was going to be raised naturally!"
We tried to give advice on how to feed it and care for its skin. But they wouldn't listen! They hadn't taken the baby to the Well Baby Clinic (for post-natal care—J.E.F.) and didn't accept medical care in general. They had read everything and knew what to do! They said they'd bring the baby back next week for a check-up. If they don't, I'm going to notify the Adoption Agency and have the baby apprehended as a case of child neglect. I couldn't do it immediately. As long as they brought it to a doctor, it can't be classified as neglect. I doubt if they'll bring it back.

Apparently what angered her was the lack of cooperation by the parents with staff in allowing them to give it "prescribed" food, and an apparent lack of commitment on their part to the medical perspective, such that they would not be persuaded to follow the legally sanctioned post-natal care routines. Instead, the "hippies" insisted on being treated as self-taught experts with the same level of competence as the staff members. As a result, the social worker implies that if it were not for their compliance with the "letter of the law" she would have had the baby "apprehended" immediately.

The law requiring a doctor's signature before a birth can be registered provides routinely for a legally enforced meeting between medical staff and lay parents which otherwise may not take place. Staff members take these encounters as opportunities to "check" on the parents' compliance with prescribed medical routines and to try to give "advice" to persuade them to see the moral necessity for the use of medical "expertise." Failing to coerce them morally, they have the authority under the law (i.e., through the medical social worker's authority) to have the baby seized and made a ward of
the court; i. e., they thereby can resort to legally sanctioned physical coercion to make medical care "available" to the newborn baby.¹

However, with regard to prenatal (as opposed to postnatal) care, staff lack the ultimate, legal means of enforcing "proper care" of the yet unborn baby. Instead, they must rely solely on moral control of the patients through attempts to persuade them to adhere to medically prescribed ways of "becoming a mother" so that in the always-oriented-to final stages (labor and delivery) they will (hopefully) be "good patients." Such attempts at moral control could be easily overheard from the waiting room bench taking place between staff and a patient in the social worker's "office" since, like all "offices" in the area, it was merely a plywood enclosed cubicle and its "walls" did not completely extend to the ceiling of the Clinic floor. For example, in the following instance, staff were overheard trying to persuade a patient not to follow her intended course of just coming to Clinic for an initial prenatal visit to determine if she is pregnant, then not coming back for "check-ups" and having her baby in a non-medical setting.

Social Worker: (sounding cross and impatient) "Why should we handle you through the clinic? The embarrassment of the blood test and pelvic and you go up in the sticks where it won't do you any good! You're seventeen and this is your first baby. You should be where you can see a doctor every month. We're not going to handle you here at all if you're just going to say goodbye! (The social
worker leaves and returns with the head nurse and introduces her to the patient as an "expert who can give you some good advice." The head nurse repeats the same line that the social worker used earlier to try to persuade the patient. When the patient is still not persuaded, the nurse brings a doctor into the "office" and introduces him as one who will be able to give her some advice. The doctor, too, tries to persuade her to go "one way or the other" and repeats the social worker's remark of either using the hospital for all her prenatal care and delivery or be refused even an initial prenatal check-up.)"

Doctor: "Remember what can happen. One time such a natural childbirth took place where the husband and wife had studied a lot of books and tried to deliver their own baby. It was healthy but dead due to their mishandling it."

Patient: "I've seen a doctor who said it's all right for me to go back in the sticks."

Head Nurse: "Don't take his advice!"

Social Worker: "I recommend seeing a public health nurse at a nearby hospital. After all what can we do when you don't care about yourself! We care more about you than you do! (Afterward she discusses the patient's case with me.) That patient is one-quarter Indian and (the Head Nurse) had talked to her before, telling her "either/or" (either she accepted hospital care for her entire prenatal and natal period or would receive no service whatsoever--J.E.F.). This time we brought in the "big artillery" (a doctor--J.E.F.) to try to persuade her. We'll have the public health nurse write to the hospital near the Indian Reservation (where the patient lives--J.E.F.). I harped at her so much because we didn't want to turn her away without service (which they did eventually do--J.E.F.). But she's so rigid about having children without medical attention!"

Again, like the birth registration case, lay adherents of non-
medical perspectives probably would try to avoid coming into contact with medical personnel except for these few specific services, over which they may be seen as having a monopoly: (e.g.) registrations of births, diagnosis of pregnancy, or providing a general physical check-up. Staff treat these isolated encounters as occasions to "check" on patients' commitment and compliance to medical routines and to attempt to morally persuade or "teach" them the value of medical care to meet their maternal "responsibilities" to the unborn child. In this case, apparently having failed to socialize and coerce her rhetorically, staff members resort to a frequently used management technique wherein they issue an "ultimatum" (staff characterizes this as telling such a patient "either/or"), telling the patient that she will not receive the service she sought on this one visit (e.g., a diagnosis of pregnancy, or a general physical check-up) unless she consents to having all her prenatal and natal (and presumably post-natal) "care" put in the hands of medical experts. In addition, staff try to teach the patient the medical purpose for their issuing this ultimatum. For example, here the social worker in her initial remarks presumes that since the patient will inevitably find the initial visit painful (the blood test) and embarrassing (the pelvic examination) she should therefore particularly want it to "do her some good" by making it the first step in the medical supervision of her entire prenatal and natal "career." In other words, the social worker is presumptively
treatment it as self-evident that the service the patient came for at the present time is not in fact the service she really seeks, because it must be tied to a sequence of medical "care" to constitute a "real service" for her. In sum, the social worker tries to teach her the medical purpose of the ultimatum so as to "inform" her that the present service she seeks is "worthless." At the same time, this rhetoric justifies the ultimatum in terms of values and ideals to which the patient would presumably respond, i.e., "doing her some good."

After providing a rationale for not giving the service which the patient requests unless she cooperates, the social worker in her next remark tries to persuade the patient on the grounds of the "medical facts" of her case. This justification for her participation in medical routines appears as an implied threat of troubles for a patient of her medical "type." ("You're seventeen and this is your first baby. You should be where you can see a doctor every month.") This case illustrates how staff draw on their medical knowledge of normal types of "troublesome patients" as a resource to persuade patients to allow them to have control over their lives during the prenatal and natal periods. In the process, staff members usually do not explicitly specify what sort of medical troubles will occur to what types of patients, nor the relative probabilities of these actually occurring in the case of the patient being thus managed. Presumably, such an "objective" evaluation would put the patient in a situation where she can, and is allowed to,
make an "informed" choice of how to conduct her life during these events. Instead, by making implicit threats of trouble staff are not treating the use of prenatal care by the patient as a matter of choice. They treat it as self-evident that any sane, reasonable woman would value their own and their baby's health, and, therefore, would heed such suggestions of possible trouble in their case. They feel responsible to society for the welfare of the mother and child and try to manage a patient by, for example, making implied threats warranted by the "medical facts" of a patient's case. They apparently assume that the patient does not have the right to risk prenatal and natal "complications."

When a patient, as in this case, resists the moral arguments and "either/or" threats of one staff member, then often that staff member will bring in "outside experts" who in turn tries to persuade her. Confronting the reluctant patient with an array of "experts" in this case leads to the most prestigious member of the management "team," the doctor, trying to scare or shock the patient with an anecdote of where a non-medical childbirth resulted in the baby's death due to the "incompetence" of self-taught lay "experts." The doctor's remark that the parents had "read a lot of books" implies that the knowledge and skills required for safe childbirth are not to be found in any source to which the patient may have access. What is further implied is that only medical staff have the expertise necessary to ensure a safe delivery and that they
would not "mishandle" the patient's delivery. As with attempts to persuade the patient to use medical prenatal care, staff do not treat the method of childbirth as a matter of choice for the patient and merely tell her the technical probabilities of the relative safety to her and her child of using different methods of childbirth. He cannot just advise that she go out and take her chances, while admitting that the hospital staff are not infallible and that occasionally they "lose" a baby due to "mishandling," too. Instead, he tries to shock her with an anecdote which implies that ex-hospital, "natural childbirths" entail a prohibitive amount of risk. The use of this sort of anecdote presumably is based on the staff's assumption that every woman shares with them a high value with regard to the life and welfare of the unborn baby, and, therefore, can be shocked into cooperating with them.

When the patient shows she is aware that health issues are involved by stating she had a doctor sanction her choice of ex-hospital, natural childbirth, the head nurse is quick to admonish her not to take his advice. The nurse in so doing implies that her doctor must be wrong, and perhaps incompetent, without first asking who that doctor might be or what knowledge he has of her case. The social worker counters her invocation of an authority to support her intended style of delivery by recommending another "expert" who, she implies, will give her "good advice." Also, staff are morally committed to prescribed medical routines to the extent that they will charge "health
workers" (a public health nurse) to "follow up" and continue
to try to manage patients. Thus, the "management team" of
"experts" aligned against the patient in the Clinic is to be
expanded to include "experts" outside the Hospital in the
patient's everyday life.

Finally, the social worker tries to justify sending
her away without any service (except, perhaps, for a lot of
advice) by using the management techniques of shaming and
morally censuring the patient. ("After all, what can we do
when you don't care about yourself!") Specifically, here the
social worker tries to put the patient in a position of shame
and moral censure by implying she has violated a "rule" of the
service relationship between doctor and patient wherein the
patient is morally entitled to receive service only if she
cooperates with staff when they are simply "trying to help
her." Also, in her final remark she implies that the patient's
lack of cooperation constitutes a morally reprehensible lack
of concern for her own (and presumably her unborn child's)
welfare. ("We care more about you than you do!") In sum,
the patient is supposed to leave the Clinic blaming herself,
not the staff, for a lack of service--since it is her own
refusal to "help herself," by cooperating, which renders her
morally unworthy to receive that service. Thus, the social
worker tries to leave the patient with the sense that her lack
of compliance with prescribed medical routines reflects on her
own moral character rather than on the correctness of those
routines.

In the following example, staff members (the social worker and a resident) try to persuade a patient who has regularly accepted medical prenatal care, not to carry out her voiced intention of giving birth in a non-medical setting. This case provides another example of the use of an "either/or" ultimatum (regarding further prenatal care which the patient seeks), with the accompanying justification for refusal of further service involving an attempt to shame and censure the patient; plus, the management technique of trying to shock the patient with a description of the possible horrible effects such a style of delivery may have on the newborn baby.

Social Worker: "The welfare of the baby is risked out there! What if the baby is born with a cord around its neck and needs oxygen?"

Patient: "Those things won't happen. I want a midwife."

Social Worker: "In this day and age there aren't any except in the northern remote parts of the province where they are used of necessity; and there's no choice. If you don't care what happens to your baby, I can't do anything more for you." (The patient appears irate and just turns around and leaves. They had been arguing in front of the receptionist's counter.)

Prior to issuing the ultimatum, the social worker explicitly appeals to the patient's assumed concern for her baby's welfare, and then tries to shock the patient with a graphic description of a possible terrible consequence for the baby if she pursues this course of action ("The welfare of the baby is risked out there! What if the baby is born with a cord around
its neck and needs oxygen!"") The patient counters by claiming the use of a midwife will prevent risking the baby's welfare. Nevertheless, the social worker tries in a vague manner to discredit midwives in general as somehow inferior to the service received in a hospital, without specifically telling her in what ways they are deficient; i. e., she does not simply tell her the objective probabilities of a safe delivery at the hands of a midwife, but suggests that they are just a "necessary evil" in some regions where hospitalization is not available. Then, the social worker proceeds to issue an ultimatum, implying that the patient's choice of a midwife delivery reflects on her moral fitness as a mother and that this means she is no longer entitled to the services of the Clinic ("If you don't care what happens to your baby, I can't do anything more for you.")

Occasionally, patients refuse to participate in standardized Clinic prenatal routines because they entail breast and pelvic examinations by a male staff member; i. e., they see these events as requiring unacceptably immodest exposure and manipulation of their bodies. As a result, such patients usually demand that a female doctor do the examinations before they will cooperate and submit to an initial obstetrical check-up. In response, staff (since there are no female doctors in the Clinic) try to protect such a standardized routine and engage in a concerted effort as a management team to try to persuade these patients that these widely held lay
considerations are not relevant to a medical setting where doctors may be male but they are "just doing their jobs"; i. e., despite the obvious sexual overtones of disrobing in front of, and being manipulated by, a strange male(s), patients are to see it as essentially a non-sexual event. Usually, however, staff members fail to persuade such a patient to accept "treatment" from a male and often turn the patient away without service. For example, in the following case staff members do not take the patient into an "office" to talk to her but instead utilize the area in front of the receptionist's counter. I take it that they remain in this area because they assume their remarks of ridicule and argument may be more effective if the patient could be made to feel publicly shamed or embarrassed for causing a "disturbance" and as a result "give in" rather than have her views castigated in public. Also illustrated in this case is the management technique wherein staff speak to each other about the patient in front of her as if she were not present, so as to provide few conversational slots or openings for the patient to be able to reply to their charges.

Social Worker: (to patient) "We try and oblige but we just don't have 'em (female doctors--J.E. F.)."

Head Nurse: (to the Social Worker) "It's just ridiculous! She's wasting her time! Our doctors see all patients who walk in the door unless they have their babies at home. So, we'd be spending a lot of money for nothing!"

Social Worker: (to the Head Nurse) "This is just ridiculous! She's twenty-one and he's twenty-four, yet she has an eighteen-year-old mind!"
Head Nurse: (to the Social Worker) "It disturbs me! This is her second baby; and she made this fuss with the first baby."

Resident: (to the Social Worker) "This is the mark of the generation gap and common-law marriage: when the young are rigid but the older more wiser and less unbending."

Head Nurse: (to Social Worker) "I don't understand it!"

Social Worker: (to the patient) "How are you going to pay for it? (the examination—J.E.F.)"

Patient: "The Province Medical Plan."

Social Worker: "You have to be in the province three months to be eligible. You'd better go back to Eastern City. (to the Head Nurse) She's seven months along." (She sounds annoyed at this fact.)

Head Nurse: (to the Social Worker) "This wastes a lot of time and money (using a female doctor—J.E.F.)! This is her second baby, too. She's lived common law for five years! She claims (the social worker's supervisor) promised her a female doctor! She never did!"

Social Worker (phones the supervisor): "I'm annoyed. (After completing the call) The supervisor says we have no female doctors."

Patient: "Why did (the supervisor) promise me?"

Social Worker: "Why do you need one?"

Patient: "I do . . ." (The patient appears to be angry and leaves the Clinic.)

Although staff treat the patient in this "nonperson" conversational manner, occasionally they, nevertheless, complained to me after the patient left that she would not listen to them and acted as if staff were not there.

Social Worker: (later discusses this case with me) "We gave her a lot ("bent" the eligibility rules on residence—J.E.F.); yet she wouldn't give in on this one thing! If she
was sixteen or seventeen and having her first child, or an older woman who had been raped or had been drunk some night, then I could understand. But she is twenty-one and no white lilly because she's been living common-law for three years and has a one year-old child. She acted as if (the Head Nurse) and myself weren't there when we tried to talk to her. I think the city is going too far in giving her what she wants. Her and her guy have been here (in the province—J.E.F.) two weeks and are on welfare. They should send them back to Eastern City. Also, she brought in a (her) child of that age who disrupted everything and we had to take care of him which really annoyed us when she wouldn't cooperate. I don't know what her angle is. Perhaps she just wants a private physician which is expensive. However, every woman who comes into the Hospital with a gynecologist's or an obstetrician's care has a pelvic and other examinations to verify her state of pregnancy, done by an intern— that's their job! And that patient didn't even know what family planning was!"

Despite the fact that she knows that the patient has already been promised a private female doctor by her supervisor ("the city"), the social worker nevertheless initially tries to convince the patient to submit to an examination by a male doctor on the grounds that the Clinic lacks female staff for this purpose ("We try and oblige, but we just don't have 'em.") For her part, the head nurse initially simply tries to ridicule and discredit her request for a female doctor as superfluous ("It's just ridiculous. She's wasting her time.") Then she tries to normalize the Clinic's routine wherein males do all the examinations, implying that the patient should cooperate since all other patients do accept such "care"
"Our doctors see all patients who walk in the door unless they have their babies at home. So, we'd be spending a lot of money for female doctors for nothing!") The social worker then joins the head nurse in debunking her request by asserting that her (assumed) plea for modesty does not befit her "age" or level of "maturity"; i.e., only a "teenager" or younger patient may appropriately demand such consideration ("This is just ridiculous. She's twenty-one and he's twenty-four; yet she has an eighteen year-old mind!") Likewise, the nurse invokes the fact that this is her second baby to imply that a patient of her "experience" may not legitimately demand ("making a fuss") that such proprieties be observed. Next the doctor tries to debunk her refusal to cooperate by treating it as a symptom of a general "social problem" (the "generation gap") and as a sign of her poor moral character ("common-law marriage"). Apparently the patient is to draw the conclusion that his generalization applies to her and, therefore, hear the terms "young" and "common-law marriage" as referring to herself. Then the social worker tries to issue an implicit ultimatum wherein the patient should leave the Clinic without service since technically she does not qualify for medical welfare, and presumably because she will not cooperate with staff members. However, she quickly rescinds this tactic because the patient is seen by her supervisor as too far advanced in her pregnancy to travel to the province where she would qualify and should, therefore, be granted the extra welfare support required for a female doctor,
if this is the only way to have her receive prenatal care
("You have to be in the province three months to be eligible.
You'd better go back to Eastern City . . . She's seven months
along.") Next, the head nurse also invokes the illegitimate
status of her relationship to her "husband" to imply she lacks
sufficient moral standing to legitimately demand that proprie-
ties surrounding immodest exposure be observed ("This wastes a
lot of time and money! This is her second baby, too. She's
lived common-law for five years!") Then the nurse switches the
focus of her attack from her lack of legitimate grounds to make
such a request to the fact that the patient has invoked the
support of the supervisor in insisting on her demand for a
female doctor.

Having failed to persuade the patient by discrediting
and ridiculing her request, staff switches topics to next try
to undermine the authority the patient has used to counter
their arguments. The head nurse tries to do this by claiming
the patient has lied about the supervisor's promise of a
female doctor ("She claims the supervisor promised her a
female doctor. She never did!") The social worker calls the
supervisor's office to try to gain some (apparent) evidence
that she is lying. She does this knowing already that because
of the patient's advanced stage of pregnancy that the super-
visor has "bent" the eligibility rules and promised a female
doctor, too. Over the phone the social worker, in fact, con-
firms that this is the case, but she nevertheless tells the
patient that the supervisor told her that the services of a female doctor cannot be provided. However, the patient apparently has not been fully convinced by this telephone ruse because she points out the inconsistency which tends to undermine the social worker's implicit claim that the supervisor does not support her request ("The supervisor says we have no female doctors.") Patient: "Why did (the supervisor) promise me?"

Rather than answer the patient's counter question and try to defend her contrived claim that the supervisor does not support the patient's request, the social worker once again switches topics, this time to the patient's motives for making her request, i.e., she tries to make the patient account for them in public while standing in front of the waiting benches. However, the patient evades the question ("Why do you need one?") Patient: "I do . . . .") Apparently, the patient will not allow herself to be thus "trapped" into making a potentially embarrassing public confession of her need for modesty. Thus, throughout the interaction, staff continuously switches topics of conversation as the patient appears not to be persuaded by first one argument and then another: the lack of female doctors in the Clinic, normalizing "care" by male doctors, invoking her "age" and previous hospitalization, invoking the "generation gap" and her lack of respectability, her lack of technical eligibility for welfare, and, finally, treating the motives for her request as problematic and publicly accountable. Finally, in her remarks to me afterwards, the
social worker makes it clear that staff particularly tried to persuade this patient to cooperate and accept male "care" because they feel the supervisor ("the city") is being "too permissive" ("I think the city is going too far in giving her what she wants.") In other words, these management efforts, normally employed with "modest" patients, are increased in this case because the supervisor (because of the patient's advanced stage of pregnancy) supports the patient's request; i.e., the supervisor usually does not subscribe to the Clinic staff's view that any patient, almost regardless of the state of pregnancy or other circumstances, is deemed "ineligible" for Welfare support and Clinic care if she refuses to participate in those routines which have sexual overtones.

Similarly, a private obstetrician relates how in dealing with "modest" patients, rather than engaging in lengthy arguments with the patient (as in the Clinic), he briefly tries to routinize the pelvic examination as "standard procedure," and teach the patient that it is medically required procedure before issuing an ultimatum wherein she must accept the procedure from himself, a male, or else be refused any service whatsoever as "his patient." Again, in the Clinic this, too, is a commonly used approach if various rhetorical moral appeals fail to persuade the patient (unless, of course, the patient can enlist the support of the social worker's supervisor).

It may seem incredible that in this day and age some women absolutely refuse to undergo pelvic examinations, but each month perhaps one or two of such supermodest types visit my office and do just that. The tip-off doesn't come until
after the preliminaries—the history taking—when I say, "Now, my nurse will take you to the examining room. Please take off all of your clothes, except your shoes. She will give you a robe."

Usually, with this kind, there is a little gasp. "But, Doctor, I never have—I mean, you don't need to examine me completely do you?"

Just how does she think I can establish the condition of her innards otherwise? By radar? I try to explain that a complete physical, including a pelvic, is standard medical procedure. At one time I would present all of the arguments for the process but this, I discovered, was largely a waste of time with the woman who is gripped by inhibitions stronger than logic. Now I simply point out that an examination is necessary and I can't accept the care of a patient without it.

"But, Doctor," is the usual reply. "Can't you just give me some tests? There's nothing wrong with me—I just want to know whether or not I'm pregnant."

The cause is lost. I repeat that I can't accept her as a patient. There is no charge. Blushing, her face tight and righteous, she leaves. Perhaps in the interest of enlightenment I should draw out the super-shy types more fully, but I'm afraid the task is one for a psychologist, not a busy obstetrician whose working hours already stretch too long. And I will admit that I'm not objective about the prudery that so long held back the development of gynecology and obstetrics. Well into the eighteenth Century the idea that a physician should inspect a respectable woman's "privates" or attend her in childbirth was considered immoral; the field was left to the granny midwives who no doubt acquired mechanical skill but little science. . . . When I think of the needless suffering and lives lost because of ridiculously overdeveloped modesty, I confess I have little time for people who still perpetuate such idiotic attitudes.

Besides the medical staff and social worker, the receptionist also engages in attempts to persuade patients to see the importance of a medically supervised regimen of prenatal care. These attempts are particularly evident when a patient comes to her counter after having missed a prior appointment for a routine prenatal check-up, such as in the
following case.

Patient: (hands an appointment slip to her) "I missed an appointment last Wednesday."

Receptionist: (very sternly) "Why?"

Patient: (shakes her head slightly) "It's not important."

Receptionist: "Why?"

Patient: "I felt good anyway and . . . ."

Receptionist: (cuts off her utterance in mid-sentence and begins scolding her) "Doctors think these check-ups are very important and should be kept!"

Patient: "But the last time they just asked me if I felt fine so . . . ."

Receptionist: (interrupts her utterance again) "But you have to be checked every week! (the patient is in her last month of pregnancy--J.E.F.) Okay. Now we'll check you today. (sternly and impatiently she says) Go to the lavatory and sit down! (Afterwards the receptionist tells me: We generally have a lot of women miss appointments and not be examined for weeks or months at a time)."

Apparently, if and when patients do cooperate and agree to have regular prenatal care in the Clinic, many nevertheless fail to see the importance of such frequent check-ups. I take it that this is a result of the fact which I discussed in the Introduction that many patients place little or no value on "preventive medicine" in general. These patients see the use of medicine as warranted only if "symptoms" or "troubles" begin to obviously interfere with their everyday life and occupational capacity. Thus, for these patients medicine takes on a "repair function" when the body begins to be unserviceable or cause noticeable discomfort. In other words, as long as they "feel
fine" in the present they see no need for medical care which is intended for the purpose of "preventive maintenance" of their bodies. However, usually the receptionist does not let a missed appointment "pass" without some effort to make the patient account for her "transgression," sanction her for it, and try to persuade her to see the importance of scheduled prenatal check-ups. The patient, herself, apparently assumes that keeping appointments is treated by the receptionist as a sanctionable matter since she manages her response so as to avoid giving her motive, which turns out to be seen as indeed sanctionable by the receptionist ("Why?" Patient: "It's not important.") However, the receptionist does not treat this as an adequate accounting for her motives and repeats her question, "Why?" When the patient gives her motive, the receptionist responds by using a commonly-used management method of interrupting or "cutting off" her explanation in mid-sentence.\(^3\) ("Why?" Patient: "I felt good anyway and . . ." Receptionist: "Doctors think these check-ups are very important and should be kept!") I take it that the use of this method reflects staff's assumption that patients do not have equal reciprocal conversational rights to speak and be heard by staff, i.e., their talk and questions can be ignored or "cut off" by staff without their being able to legitimately sanction staff members, but the opposite does not legitimately hold for the staff members' talk and questions to the patient. The receptionist uses this method again when the patient tries to protest the validity of her
reason for missing an appointment. (Patient: "But the last time they just asked me if I felt fine, so . . ." Receptionist: "But you have to be checked every week!") I assert that this may be a commonly-used method of doing scolding wherein staff, acting as management agents, ask a patient for the reason for a "transgression" and then "cut off" or not give a polite or full hearing to the patient's account before taking their next turn in the conversation.

Although the receptionist has explicitly asked the patient for her reasons for missing an appointment, her scolding remark implies that whatever reason the patient may feel to be adequate is in fact not valid or important since "she is not an expert or an authority" like the doctors who "know what is best for her." ("Doctors think these check-ups are very important and should be kept!") Also, in this remark the receptionist implies that she believes that no matter what reason the patient may give, the real reason is that the patient does not see the essential importance of strictly adhering to a medically supervised prenatal regimen of "care." Thus, evidently she is relying on an assumption of what typically or normally motivates absenteeism (a difference in cultural perspective) in order to scold her presumptively without first listening to all of the patient's reasons. In the second interruption of the patient's account, the receptionist apparently is trying to teach the patient that how she feels is irrelevant--it is a matter of the normative character of
the medical routine ("But you have to be checked every week!"). In other words, I take it that here she is reminding the patient of one of the rules of the Clinic, implying that the patient should treat them (the rules) as normative matters binding on her behavior.

In addition to trying to persuade patients to accept medically supervised prenatal care and childbirth, staff members try to teach patients to "properly" organize their lives in preparation for parenthood, including their financial and marital affairs, as well as their housing situation. The social worker, especially, tries to control by moral persuasion patients' occupational and marital lives so as to ensure a "sound" future for the baby. Most of this attempted management occurs when the social worker is interviewing the patient to gather information to determine eligibility for Welfare, and to fill out the Social Profile sheet in the patient's medical history file. Instead of merely asking questions in a straightforward manner about the patient's social and financial circumstances and recording her responses, often she turns the interview into a didactic session wherein she initially asks presumptuous "leading" questions (and rhetorical questions), apparently intended to encourage the patient to infer the existence of moral and "social" problems in her life and then offers "advice" about what the patient and her "husband" could (intended to be heard as "should") do about these "pressing" problems. In other words, the social worker, by her
choice of topics and manner of questioning, tries to get the patient to see that her financial or marital situation constitutes a set of "problems" for which the patient is morally responsible so that when she finally offers her advice it is more likely to be heeded by the patient as morally binding on her behavior.

(The patient enters the social worker's office and sits down.)

Social Worker: "Are you pregnant?"
Patient: "I don't know yet."
Social Worker: "Where are you from?"
Patient: _______.
Social Worker: "I never heard of it. Is it small?"
Patient: "Yes."
Social Worker: "Is it near Midwest City?"
Patient: "No."
Social Worker: "Do you have any health problems?"
Patient: "I've had mono."
Social Worker: "You're pretty sure! Ha! Ha! Did you want to get pregnant or did it just happen?"
Patient: "Oh. I wanted a baby."
Social Worker: "Has your husband worked during the last six months?"
Patient: "No."
Social Worker: (looking at the face sheet information before her) "He hasn't had any work since he came to this city; and he has two years of college? Is he not motivated?"
Patient: "I don't know."

Social Worker: "He could get a job on campus and you, too. I can see why the Adoption Agency (where he tried to find work—J.E.F.) didn't want to hire him. He hasn't a degree!"

I take it that the question concerning whether she wanted to get pregnant is intended to check out how "welcome" this baby is. It is phrased in such a way as to imply that for a pregnancy to be "welcome" it must be rationally planned. In fact, the patient in her response shows she has heard the intended question to be the desirability of the baby and not merely the literal one of whether the pregnancy was planned; i.e., she responds to the intended or "leading" character of the question. Next, note that the social worker does not merely record the "No." response to her question about her husband working but instead uses the information on the face sheet completed by the social worker's assistant to provide a warrant to ask a presumptive and accusatory question about her husband's "apparent" lack of motivation. ("He hasn't had any work since he came to this city; and he has two years of college? Is he not motivated?") In the process, she presumptively suggests that both she and her husband are to blame (due to a lack of motivation) for not being employed and then offers the advice that both she and her husband seek employment on a nearby college campus.

When the social worker encounters these patients with "problems" in the waiting room on subsequent check-ups, she
often "follows up" on her earlier management attempts if, for example, the patient's husband still is unemployed or their living quarters are still seen to be "unsatisfactory" with chastisements and reminders of the necessity of getting off welfare in order to be able to pay for the new baby. In the following example the social worker happens to encounter a patient in front of the receptionist's counter when she returns to the Clinic for a routine prenatal check-up.

Social Worker: "Hi, Mary. How are you?"
Patient: "Fine."
Social Worker: "What? No baby, yet?" (The patient is in the last stages of pregnancy--J.E.F.)
Patient: "I've moved."
Social Worker: "What's your new address?" (The patient tells her.) "Is it a house or an apartment? How many rooms?"
Patient: "Two."
Social Worker: "Two bedrooms, furnished?"
Patient: "Yes."
Social Worker: "Your husband working yet?"
Patient: "No."
Social Worker: (frowns) "What! No job!"
Patient: "He can't find one."
Social Worker: (angry tone of voice) "Are you living in a hotel like last time?"
Patient: "Yes."
Social Worker: "Are you going to keep the baby?"
Patient: "Yes."
Social Worker: "What about clothes for the baby?"

Patient: "I don't know yet."

Social Worker: (sounding annoyed) "Just how do you expect to pay for all this? Out of Welfare? You know that money comes out of my pocket, too!"

At the news that the husband is not working yet she gets angry and begins denigrating their living situation. Also, this news apparently makes the "financial future" for the baby more problematic so she brings up the topic of adoption and reminds the patient of the expense entailed in buying baby clothes. She tries to point up the importance of her husband finding a job by pointing out the patient's financial responsibility. ("Just how do you expect to pay for all this?") Since the husband has not yet found a job, the social worker presumes that they are planning to live on Welfare; so, she implies that Welfare will not be adequate for this purpose. Also, she claims the patient is taking money from her personally when she accepts Welfare. Thus, the social worker implies that taking Welfare at all is immoral because it involves forcing her and other taxpayers to pay for the patient's and her family's support.

In addition to these efforts observed in the waiting area, I found that occasionally the doctors in the pelvic examination, or cubicle area included similar management attempts in their interviews with the patient.

Resident: "You've been pregnant before?"

Patient: "No."
Resident:  "How old are you?"
Patient:  "Seventeen."
Resident:  "Where are you from?"
Patient:  "North City."
Resident:  "Where do you go to school?"
Patient:  "I have been working."
Resident:  "How long?"
Patient:  "One year."
Resident:  "Did you get pregnant in North City or come over here?"
Patient:  "I don't know when I got pregnant."
Resident:  "Does your husband work?"
Patient:  "No."
Resident:  "How much do you make?"
Patient:  "Three hundred dollars a month."
Resident:  "Where is your husband going to get work?"
Patient:  "I don't know."

Here the doctor apparently tries to show the patient that in order to raise a child both she and her husband are going to have to work. He does not tell her this explicitly, but simply leaves it up to her to draw this conclusion from his presumptuous question, "Where is your husband going to get work?" In another case, a resident uses the same management technique of asking presumptuous "leading" questions.

Resident:  "What kind of work do you want?"
Patient:  "I don't know."
Resident: "You should see the social worker." (Later in the interview the resident shows he has read the patient's file which states her husband works as a filling station attendant.) "How is your husband getting along at the gas station?"

Patient: "Okay."

Resident: "Chance of anything better?"

Patient: "I don't know."

Resident: "As long as you are not afraid to go out of town, he can get better wages."

Here the resident introduces the topic of her financial situation by a presumptuous question which assumes she desires to (and indeed should) go to work. He then asks a "leading" question about her husband's success on his current job. I take it that he already believes that this job has "undesirably" limited possibilities for increased income, which he presumes they need, and therefore is not seriously interested in how successful he is but just wants to "set up" or provide for the relevance of his next presumptuous question, "Chance of anything better?" This question provides a way of showing the patient that her husband should be more ambitious without having to explicitly admonish her to this effect. His final remark suggests he has gathered from her responses (and probably already suspected) an apparent lack of ambition on the part of her husband. However, instead of merely stating his advice in a straightforward manner ("There's more opportunity out of town.") he formulates it as a mild cajole or coaxing which challenges her to move out of town so he can advance
occupationally ("As long as you are not afraid to go out of town, he can get better wages.")

Besides trying to manage the prospective parents' financial, occupational, and housing situations, staff often build into their questions concerns for the permanency of the parental relationship and the consequent legitimacy of the yet unborn baby. Such a didactic approach apparently is intended to allow the patient to draw her own conclusions as to the need to be future-oriented and to provide for the permanency (and respectability) of the family relationship. The following excerpt from an interview between a pregnant patient and the social worker provides an example of the use of this method of presumptuous questioning.

Social Worker: "How long have you lived common-law with your guy?"
Patient: "Six months."
Social Worker: "Are you on Welfare?"
Patient: "No."
Social Worker: "What does he do?"
Patient: "He's a carpenter."
Social Worker: "What does the future hold? Do you think you'll get married?"
Patient: "I don't know."

Apparently the social worker wants the patient to see herself as involved in an "impermanent" relationship and implies that this requires changing for the future and that the patient should consider (or has considered) marriage as a possible future course of action.
Finally, I would like to conclude this chapter with a discussion of how clinic staff in the waiting room (and cubicle area) endeavor to persuade patients to adhere to a medically prescribed prenatal dietary regimen. For example, when the head nurse weighs patients on every visit, she does not merely record their weight on their medical history charts and tell them what they weigh; she also includes a loud, publicly stated moral censure if they have gained any weight, and loud approbation if they have lost any weight ("You've lost a pound! Good girl! I am proud of you!") Apparently the nurse sees her routine task as including attempts to persuade patients to see the importance of limiting weight gain by controlling their diets for the "sake of the baby's health," and to avoid "complications" during pregnancy. However, from my observations this appeared to be a chronic, irremediable "problem" for her (and the rest of the staff) because it is the result of cross-cultural differences between them and patients. For example, while patient's waited at the benches many of their conversations dealt with such topics as eating, their favorite foods, and their large appetites. Apparently many patients did not regard the gestation period as being governed by medicalized food rules, but instead as a period where they continued their pre-pregnancy dietary habits. This cultural difference results in the common occurrence of the following sort of attempt at persuasion at the weighing scale.

Head Nurse: "You've gained three pounds! That's too much even for an Italian who eats spaghetti!"
(The social worker happens to be walking by and overhears this exchange. Without invitation, she offers her advice.)

Social Worker: "Italian who eats spaghetti, eh? You better cut down!"

As with managing patients with regard to other cross-cultural issues, the social worker often spontaneously "teamed-up" with the head nurse against a patient when the occasion seemed to require it. Here the head nurse uses the commonly-used method of tying a sanction for weight gain to a presumptive character assessment of the patient; e.g., she may draw on the commonly held assumption (among Clinic staff) that patients with "Italian" surnames often continue their pre-pregnancy, "typically Italian," diets which include medically prohibited large amounts of starch. In other words, staff members often draw on shared ethnic typifications of patients in doing sanctioning, which are assumed to be related to the normal dietary violations assumed to be indicated by weight gains.

Thus, in sanctioning patients, staff members typically make two sorts of presumptions: (1) Any weight gain is the patient's moral responsibility and due to her violation of dietary norms. (2) These violations are the result of patient's adhering to her ethnic (or religious) subcultural dietary habits.

When a patient does not exhibit any easily recognized signs of a particular ethnic affiliation, the head nurse may just presumptively accuse the patient of some general violation (e.g., "over-eating") of dietary rules if she has gained any weight. Head Nurse: "You gained four pounds! You've been
over-eating!"

In some cases of this type, censure and admonition may be more indirectly expressed and include a vague threat of (presumed) undesirable effects on the patient's aesthetic appearance if she does not discontinue her (presumed) violations. For example, in the following instance the head nurse weighs a tall patient and whistles gently before announcing her weight.

"158 pounds! You better slow down or you are going to be a very big lady."

Apparently the head nurse assumes that a lay patient may be more concerned for her appearance than any medical significance of gaining weight.

Besides trying to manage patients when they are weighed, the head nurse often monitors patients' conversations while they wait on the benches for references to "bad food habits" and often interrupts this talk with sanctions or reminders of the necessity of observing medical dietary rules and limiting the amount of weight gained during their pregnancy. She engages in these management attempts particularly with the "girls" from the Home for unwed mothers because they sit on the benches nearest the scales where she spends much of her time. For example, during one Clinic session the patients discuss plans for how they will celebrate Halloween (including the "smuggling" into the Home of their favorite--though "prohibited"--foods) in the Home.

Patient: (to the group of patients) "What are we going to do for Halloween?"
Head Nurse: "Are you going "trick or treat?"
Patient: "I don't know."
Head Nurse: "Maybe you'll get bigger than!"

A common account (staff call them "excuses") the head nurse hears when patients try to explain the reason for weight gains is that a "special occasion," like a holiday or birthday, "required" her to "over-eat" and violate the medically prescribed diet. Also, she assumes that such events do in fact frequently result in sanctionable weight gains. Thus, here she anticipates the possible "adverse" effects of such an event and indirectly warns them to be aware of the possible sanctionable results (an "unattractive" weight gain—"you'll get bigger then!") of engaging in "violations" of the prescribed diet that these holidays ritually entail.

Besides discussions of "ritual eating," a common topic of conversation among the waiting Home patients is their favorite foods and what they are going to eat after the Clinic session, including going to a nearby drug store for various ("prohibited") fountain treats. Often the head nurse will cut into these conversations and sanction their repeated references to eating and food. The following is an example of this sort of management attempt:

(The patients are discussing how hungry they are and the food they intend to eat after the session, when the head nurse interrupts with a question for the group.)

Head Nurse: "What did you have to eat today?"
Patient: "Nothing."
Head Nurse: "That's right! You don't eat on Clinic day! That's why you're always talking about food!"

The head nurse evidently was already aware that many patients do not eat on "Clinic day" in order to try to compensate for their "transgressions" during the rest of the week and to at least temporarily reduce their weight, so as to avoid being sanctioned by Clinic staff or even being hospitalized for possible "complications" due to weight gained during the pregnancy. In other words, she probably already knows the answer to her question, "What did you have to eat today?" even before she asked it. Thus, instead of issuing a straightforward sanction for their "devious" or "irregular" dietary practices, she "traps" the patients into a "confession" of abstaining from food by asking an apparently innocuous "leading" question in order to "set up" or warrant her sanctioning remarks, "That's right! You don't eat on Clinic day! That's why you're always talking about food!"

This case also illustrates the fact that apparently staff not only want the patients to control their dietary habits but also their talk to each other about food; perhaps on the grounds that "careless" or "indulgent" talk is seen to undermine any possible "positive" effect that staff's management efforts might have had on them. On the other hand, if and when staff over-hear the patients discussing the medical "dangers" of various types of foods during pregnancy they usually do not try to join the conversation. Thus staff
usually interrupt only to issue a reprimand (e.g., "... you're always talking about food!") when patients are discussing how hungry they are or "prohibited" sorts of food, which are also the patient's favorites. In sum, apparently staff see the patients' conversations as part of the management process and therefore monitor it to control it and provide for a continuity between the staff's socialization talk and the content of conversational exchanges between waiting patients.

After the patients have all been weighed and properly sanctioned (positively or negatively), they wait on the benches to be instructed by the head nurse to go back into the cubicle area "to see the doctor." During this period, the receptionist, whose counter is near the Home patients' bench, will remind the waiting patients of their responsibility to "watch their weight." The following case illustrates the method by which she does this reminding.

(The receptionist leans over the counter, looks at the Home patients, and loudly asks the group the following question.)

Receptionist: "Who has gained a lot of weight today?"

Patients: (Many patients giggle nervously and they respond with a chorus of:) "Not me! Not me! Not me!"

I take it that here the receptionist is not trying to monitor or sanction any one individual's weight gain, but instead is doing what a school teacher does when she asks her class at the beginning of the session, "Who has done the homework assignment?" In other words, she is relying on what she
assumes will be a large number of positive responses (e.g., a chorus of "Not me," or for the teacher, "I have!") to have the effect of making whoever has not been "good" feel shamed or sanctioned. Apparently, she is trying to "follow-up" the head nurse's moral treatment of particular individuals with this tactic of using the "group" to provide a public setting so that those patients that have not gained (or have lost) weight may have some sense of "recognition" (or "reward") for their "achievement", whereas the "bad" patients who have gained weight are not allowed to leave the waiting room without this one last reminder of their "violations" of the rule "weight gains are prohibited."

Like the head nurse in the waiting area, staff in the cubicle area assumed any weight gain was the responsibility of the patient, and treated it as presumptive evidence that she had "violated" rules about "watching her weight" and adhering to a diet. As a result, they sanctioned any weight gain and debunked any reason the patient gave for the assumed "violation" of the diet, or a weight gain, as being "excuses"—implying she had deliberately sought to "transgress."

Typically, these reasons, or "excuses," involved celebrations and holidays where eating is regarded an integral part of, or ritually required, in such events. Despite the doctors' lectures and subsequent sanctions for "transgressions" during check-ups, patients frequently arrived in the Clinic after
these events with what staff saw as "sanctionable" weight gains. In other words, many patients still regarded the prescriptions and proscriptions governing these events as taking priority over medical dietary rules. Thus, this provided a common issue for cross-cultural conflict in routine prenatal check-ups.

Resident: "Hi! How are you?"

Patient: "This is the big month, eh?" (Her ninth month of pregnancy—J.E.F.) "At last. I gained three pounds."

Resident: "Tisk! Tisk! Are you watching your weight?"

Patient: "I try, but we had a birthday celebration."

Resident: "I keep hearing those excuses all the time!" (Later in the examination) "Here are some sleeping pills." (She had complained of not being able to sleep.) "Take one. This weight! You'll watch it!"

In the following case a Resident treats a patient's observably obese condition as presumptive evidence of her not "staying" on the diet and as grounds to sanction her for willfully resisting the dietary advice, i.e., being "stubborn." He then follows this effort with a "scare story" similar to that used by staff to try to manage patients in the waiting area and cubicles who voice their intentions to have their child in a non-medical setting. Here the resident is accompanied by several students.

Resident: "How's your health?"

Patient: "Okay."

Resident: "She's had a urine analysis, have you?" (He looks at the hemoglobin count on her chart.) "Have you had iron?"

Patient: "No."
Resident: (to the students) "Why hasn't she been given any iron?" (He grabs a handful of her abdomen and asks the students) "What's this?"

(The students appear surprised and puzzled at his question.)

Student: "Fat and stretch marks."

Resident: (to the patient) "Stay on your diet! No starches or grease!" (The patient laughs nervously, and he responds) "This is no game! Don't be stubborn! We're not playing any games! Too much weight put one girl in the hospital and caused disposal of her baby and liver damage."

He physically sanctions her by roughly grabbing a handful of the offending "fat," and displaying it to the students as such seems to be an attempt to "shame" the patient. In other words, he takes advantage of the teaching situation to treat the "fat" as a teaching object ("What's this?"); thereby using the students as an audience with which to "shame" or degrade her as being "over-weight." The patient then laughs nervously, apparently from embarrassment at being thus "displayed." However, the resident interprets this laugh as meaning she is being "smart," or making light of his admonitions. As a result, he proceeds to presumptively sanction her for not adopting the prescribed attitude on the importance of weight control, i.e., treating it as a "game." ("This is no game!") Next, he tries to impress on her that this is "serious business" by relating an anecdote of the "troubles" experienced by another patient who gained too much weight during pregnancy. As with the management of "natural childbirth" patients, staff
members do not treat the patient's diet or the weight she gains as a matter for her choice. As a result, they do not simply tell patients technical probabilities of the relative safety of different dietary practices or varying amounts of weight gains to them and their off-spring, and permit them to make decisions about these matters. Instead, they try to shock patients with anecdotes which imply that serious harm to them and their babies inevitably follows from not following the prescribed dietary regimen. Presumably, the use of this type of story is based on the staff's assumption that any woman would share their great concern for life, and, therefore, would be shocked into compliance with the regimen. Above all, staff appear to feel responsible to society for the welfare of the unborn child, and consequently try to persuade the patient to give up her apparent "stubbornness" and view it as a life and death matter.
1. However, it is quite unusual for the Social Worker actually to use this right to make the baby the ward of the court. Typically, in gaining the compliance of "recalcitrant" parents, the threat of doing this is sufficient. Furthermore, even if parents continue to resist, the Social Worker usually does not exercise her right unless the baby exhibits "serious effects" from their "negligent" treatment.


3. Bruce Katz has described how doctors in two-party therapy conversations may use the management technique of interrupting or "cutting off" a patient's utterance in order to sanction him or emphasize a point. See Bruce Katz, "Conversational Resources of Two-Person Psychotherapy" (unpublished Master's thesis, University of British Columbia, Vancouver, B.C., 1971).
CHAPTER IV

IMPLEMENTING A MEDICAL IDEOLOGY IN PRENATAL WORK ROUTINES

This chapter deals with patient management techniques I found in the cubicle area where pelvic examinations, general prenatal physical examinations, and prenatal lectures are given to obstetrical patients. Here I will try to demonstrate how work exigencies such as work scheduling and providing a visibly competent performance result in only the occasional implementation of the ideals of the medical ideology (including the "necessity" to "teach" patients, treat their "individual" problems, and give proprietary care) in regard to patient management techniques; an approach to patient "care" and the teaching of students I term the "technical approach"—(as opposed to the academically-located "patient as person" medical philosophy or approach which supports the more consistent implementation of ideological ideals in everyday work routines). Since medical students do the bulk of the work in this area, I will pay particular attention to analyzing their organizational problems, work orientations, concerns with "getting through" prenatal interviews and general examinations in a visibly competent manner, etc. Some of the supervisory contact is oriented to "making physicians" of medical students. In this process,
supervising physicians may give "pep talks" containing ideal "ideological" components on the "patient as person" approach, as I have termed it, but seem largely to ignore students' practical work problems. In other words, in these didactic sessions, the "technical approach" the medical philosophy, generally implicit, which is most commonly followed by residents and medical students in the cubicle area and delivery room, as well as by staff in the intake area to patient management may be down-graded as a medical philosophy, but students have to come to terms with the demand characteristics of the situation (e.g., work scheduling and visible competence) once they get to the cubicles where they actually work with patients.

Taking the Medical History

In the City Outpatient Clinic, the bulk of the prenatal and gynecological pelvic examinations are performed by third year medical students. They take the medical history by interviewing the patient, do a general, cursory examination, and find a resident to supervise their doing of the "internal examination." The "history" form is filled out by the student on the patient's first visit and is used by students and residents on subsequent check-ups. A "pelvic" is done on the first visit to take a Pap smear, check for gynecological problems, as well as assess the pelvic bone structure for its adequacy in allowing a vaginal delivery. Another "internal" is routinely performed shortly before the estimated delivery date to assess the expansion of the uterus and check for any additional
gynecological problems. A "pelvic" may be given on one of the intervening routine monthly check-ups if the patient complains of vaginal troubles, or problems are detected with regard to the fetus. There are usually only two residents on duty, plus an intern, to supervise eight curtained cubicles. As a result, students do most of their work unsupervised. Even when the resident attends the pelvic, he is usually quickly called away to another cubicle, allowing little time to "teach." However, the students are there to learn, so they learn primarily "by doing." The only formal teaching session occurs on the third year students' first visit to the clinic. On those occasions, usually four or five students appear in the waiting area at 1:00 and wait for the teaching obstetrician, Dr. Bartlett, who arrives around 1:20 to deliver a lecture in one of the seminar rooms on the second floor. Following the "orientation lecture," the doctor and students, as a group, do an initial obstetrical visit, including the pelvic examination. These lectures deal with how to do pelvic examinations, physiology, and the general operation of the clinic. Much of these didactic sessions consist of "pep-talks" concerning lack of patient cooperation due to the cross-cultural character of their encounters with patients, as well as "tips" on how to manage them.

Dr. Bartlett: "This is an outpatient gynecology and obstetrical clinic. The patients consist of those who aren't receiving (for some reason) private care. Some by choice like the clinic, and regard City as their "doctor." On the other hand, some are down and out. Some are in trouble with the law and come from jail. Unmarried girls are
from the Home, and a lot of Indians who have no resources of their own. Obstetrical patients come in directly to the obstetrical clinic. Gynecology patients can be referred from the Outpatient Department. The patients get pushed around by the bureaucracy. There aren't enough doctors to give care, and what's more important, the care is not consistent--doctors think differently--they see a different doctor each time. Patients sometimes feel they don't need care. Be this as it may. We have obstetrics (whether a problem to the patient or not) and they need care.

The girl (patient) has got ideas of doctors as being made of iron; so, when you tell them about watching their diets, they may be convinced. She doesn't like needles and wonders if she can avoid them; damned if she'll let us.

The disadvantage of the clinic is that a lot of patients know they can get away with weight gains; and they don't have to stand for any arguments about iron either; or else they can go elsewhere. In private practice, she pays her money and comes, so she decides to follow instructions. So, we need to establish a good relationship between doctor and patient to use the peculiar authority of the doctor to get them to accept treatment they may not like. An iron needle irritates, stings, unless by expectation it hurts. A lot of girls have tattoos which are done by iron needles, and getting these done doesn't hurt the girl, anyway. Doctors are on pedestals to people. People think they earn too much and are wealthy S.O.B.s. Yet, they think they pack authority and can use it. But doctors can only use it if they use their tools: their behavior and dress."

Here Bartlett emphasizes the differences between the private and clinic patient. He points out how the clinic routinely has patients that require "arguments" by a staff willing to exert their "authority" (moral control) to transform them into...
"proper" mothers-to-be who are future-oriented and allow their lives to be governed by a prenatal medical regimen. He makes an effort to "debunk" lay resistance to needles as being founded on unwarranted fears ("expectations") or "scare stories." He admonishes them to see such resistance "for what it is" and exert their authority to overcome it (as did the head nurse in the intake area). He exhorts them to establish a "good relationship" with the patient so that their "peculiar authority" can be used to get the patient to cooperate, despite her beliefs and "expectations." He implies that such a relationship is contingent on the skillful management of their dress and behavior vis-a-vis the patient. The primary "moral" of this initial part of the lecture seems to be that "if we are going to make good mothers-to-be out of these 'poor' patients the relationship we establish with them is as important as technical skills."

During the rest of his lecture he usually becomes more specific as to the cross-cultural "problem" areas, as well as the aspects of "dress and behavior," to be managed to establish a relationship in which moral control may be exerted over the patient.

Dr. Bartlett: "Any patient responds to how you treat them; and you respond to how the patient treats you. If the patient gets flippant and saucy, you do too. You should respond differently and not try to get back at the patient if she's impolite. You have to know your own relationship to the patient to know how to assess your reaction. Whether the patient uses drugs, smokes, your emotional relationship to the patient. This relationship effects your putting an accurate assessment
on the (physical and "internal" examination) chart. Basically, it's communication: keep it open in the following way. First, be friendly without being too friendly, or familiar. Second, use the milk of human kindness. Remember, they lacked the things we had; and don't forget how you are treating them. Talk to them as persons. Keep careless talk and laughter to a minimum. The patient is paranoid, and assumes it applies to her. This is especially true as each examination booth can be overheard, so you see it tramped on all the time. Despite their low economic status, the patient is frightened because they often have never undressed in front of a man, so it's important to close off the booth. So, treat the patient as a sister and learn to do things skillfully so you hurt her less. Keep your hands and stethoscope warm. Move slowly and accurately. If you hurt the patient, apologize, and let 'em know you're a human being."

(A lecture after doing the pelvic as a group)

Dr. Bartlett: "One thing you have to do is to establish rapport with a patient. This one we just examined is cooperative. No problems. But you have to be able to talk to anyone whether they have bad breath, bad teeth, or make a face like an ugly person, or is snotty with you. This is especially important for the vaginal (examination)."

His talks point out how medical personnel try to organize the events surrounding prenatal care into non-sexual occasions. However, it is a management problem because through and through, it has obvious sexual overtones. He warns them to avoid sexual implications. He tries to get them to adopt his model of the patient as an "unfortunate sister" whereby "even though you treat them like cattle in the clinic, treat them as doctors." He admonishes them to understand "unfortunates" and develop the last little refinements of civility, privacy,
and modesty to establish a "good relationship" whereby their (the patients') behavior may be controlled. Their behavior is supposed to be ideal, since they are on a pedestal now.

He gives them these "pep-talks," even though he assumes they have these attitudes already. His talks clearly assume this since he explicitly tells them how to be praiseworthy vis-à-vis professional ideals; but he does not have to instruct them to have the "right attitude," i.e., "treat maternity as honorific and sacred." Thus, he clearly shows he does not have to socialize them out of a "lay non-medical" perspective, but can assume "proper" pre-professional socialization. In sum, he does not explain why they should adopt these techniques, but instead commands them to be ready to perform them and "pay lip-service" to the values embodied in the "medical" perspective.

In his lectures, Bartlett charges them to observe professional proprieties of modesty by reducing the number of pelvic examinations, using the methods of draping, and having a nurse present. Such attempts at managing sexual overtones serve, according to the doctor, to gain the cooperation of the patient, as well as preventing those overtones from becoming grounds for impugning the competence of the doctor.

Dr. Bartlett: "During the active labor period, after the patient has been admitted to the hospital, nurses lean a lot on rectal exams to see how the cervix is dilating and the baby is coming. This is not the best way to assess labor. Patients hate it. It hurts. Nurses depend on it, and do it too often. They don't use common sense: whether there is
a bloody show, how often and strong are the contractions, and how the membranes are. Only if she gets a lot of pain, do your exam. Three vaginal exams are all you need. Use fingers—they give a more accurate feel; and it's more comfortable for the patient. It's the nurses' custom not to do vaginals. Nursing schools do medicine on an authoritative, arbitrary basis; plus, the nurses' books say not to. People believe it's liable to cause infection if you use your hand; but she probably had a big ding in her twenty-four hours before, anyway. Always use utter politeness. Don't be rude and hoity-toity. Expose adequately, but not unnecessarily, and respect modesty. You should have a nurse attending, if it's a young girl. Don't usually do an examination unless this is the case. Otherwise, I've been in practice 15 years and never had an accusation. It's a waste of time to always have to find a nurse and have one present. Besides, you can't do anything nasty down in that farm. You hear everything. When the girl is being put up in the stirrups, you don't have to leave, but it's a matter of courtesy. The patient and you have to get down in an undignified position; and there isn't enough room to work."

He poses his approach as "common-sense," as opposed to "authoritative, arbitrary" medicine; whereby, students are to rely on ad hoc judgment of the progress of labor to "individualize" the number and timing of examinations. He invokes a view of the normal obstetrical patient and her sex life to debunk the stylized text-book approach. However, he does not use the dictionary term ("intercourse") to refer to this presumably normal "contamination," but a more "crude," folk sexual reference ("big ding"). This lecture illustrates how staff in their backstage talk routinely exhibit the non-medical or lay view of pelvic examination and delivery events as having obvious
sexual and prurient character. I found that when he wanted to emphasize or graphically describe some aspect of the pelvic examination, he employed these non-dictionary references, apparently as a pedagogical device. At the same time, he strongly admonishes them to control sexual implications in the front stage by "being polite," limiting exposure, and having a nurse present to act as chaperone. He seems to assume there is variation among patients as to their "sensitivity" to sexual overtones and, consequently, tendency to confront a doctor with them in the form of an explicit accusation. He warns them to vary their techniques of reducing sexual overtones according to shared categories of normal types of patients; e.g., a "young girl" requires a "chaperone" nurse. For other types of patients, he asserts it is "a waste of time," at least partially because of the essentially public character of communication in the cubicles.

In instructing students on how to conduct the medical history interview, Bartlett gives particular attention to that section of the history form called the "sex-marital inquiry."

Dr. Bartlett: "For the sex-marital inquiry you should learn to ask personal questions. Know yourself and don't do it for vicarious reasons. Ask only the questions, and don't appear to take a vicarious interest. Learn how to get the information out of her. You'll have a scared seventeen year-old, and you'll ask her whether she's having intercourse. You should learn to establish rapport to get the information, so pass over these questions casually, so neither she, nor you, gets embarrassed. Don't ask if she's been pregnant before, since she'll
automatically and definitely say no. Conduct a systematic inquiry so the marital and pregnancy answers will appear to be given routinely as part of the whole interview. You're going to get a certain amount of misinformation; and you have to learn to minimize it as best you can. You want to know the chances of getting pregnant. She may tell you she had a period two weeks ago, but it may not be a period. You have got to find out if she screws, Ha! Ha! or has intercourse. Tell 'em no information is going to be blabbed around. Tell 'em, I want to do the right thing by you; and that this is not a time to be playing games. Tell 'em it's not a time to be reticent, and that she'll be chiselling only herself if it's not the truth. She will say a few times a while back, or on a regular basis, or a few times a week. Get the information! Learn to be ultraobservant!

His lecture reveals that staff are aware that the "medical history" may be another cross-cultural issue for the patient and doctor. The patients seem to believe that "there's us and the la-de-da doctors." Consequently, their responses to such questions reveal that they treat them not so much as medical events of purely technical import, but as governed by proprieties that non-medical or "normal" scenes of inquiry carry. Accordingly, they will organize their responses so that they fall within the accepted proprieties; e.g., they will not tell staff about their sex appetites (implied in the question on rate of intercourse), especially if they are great. Bartlett seems to take it for granted that the normal, or "typical," patient will assume that if they give an "outrageous" response to such inquiries, the doctor will not treat it so much as a medically interesting fact, but as a disreputably poor phenomenon. Because of this management process, he
warns, the patient will be shaping information. Nevertheless, Bartlett sees it as an important result of his instruction that students be able to get "accurate" information to fill out the history and physical examination forms. This requires not only that they manage the pelvic examination as a non-sexual event to get the patient to relax and cooperate, but also manage the sexual overtones of the "medical history" so that the patient will treat "personal questions" as they presumably do the rest of the medical inquiry, i.e., as purely technical questions asked "for her own good." However, he makes it clear that these questions are different for the staff, also. He implies that they, like the patients, will find them to be of prurient interest and provoke embarrassment. Thus, although these are doctors-in-training, he assumes that typically they share with patients the view that such inquiries are through and through sexual events. He warns them that if sexual overtones are to be managed for the patient, then they must also manage their own presentations and not ask questions spontaneously, which might reveal to the patient what she believes already: staff do not treat such inquiries in purely technical ways.

Bartlett's sexual jokes ("... ask her if she 'screws,' ha! ha! ...") in the backstage teaching setting suggests that not only students, but he, too, treats these as more than technical matters.

Normally, part of the orientation lecture is also devoted to instructing students on the necessity of managing
their appearance and behavior to conceal or reduce the visibility of information as to their student status in order to "pass" as doctors. They are admonished to work to gain the patient's trust in their competence, including engaging in "passing devices," whereby, they may avoid appearing ignorant in answering a patient's questions and appearing "studentish" in dress and manner.

Dr. Bartlett: "The purpose of the clinic is to give the student contact with patients. Here he is regarded as a doctor. He dresses, behaves, and is addressed as a doctor. The students start out scared; and the patients are scared, too. The students don't have to be. You have a responsibility as a teacher and student to watch to see if you have a respectable appearance. Some groups of patients, I wonder if it makes any difference to them. Whether a patient will trust a dirty, smelly person is a matter of question, but it is the image of the doctor to wear a white coat, shirt, and tie, and be clean. Learn and help the patient. Don't be too studentish with them. If they ask questions, answer them if you can. If you can't, then shift direction to ward off questions. Use a line of patter as a device to deflect questions. Refer to each other as doctor. A lot of patients know you're students. Some think you're young doctors. But most patients won't ask directly, so call each other doctor. The doctor-patient relationship is a matter of two people: there may be different ideas in the minds of patient A and B, but they won't question the doctor as long as he appears competent. If you get stuck (during the examination), come to me. You should develop your own glibness; such as "let's talk about that later," or "Dr. Bartlett can better answer that." Develop your own system. I'd like to be there for the pelvic examination only."

Bartlett usually just mentions in passing that some patients will believe they are young doctors. Apparently, it would not
be as pedagogically efficacious for students to take for granted that their credentials for doing medicine would automatically be established with most patients. If students assumed they already had the patient's trust in their competence, presumably this would allow them to focus entirely on the technical aspects of treatment which they are learning and not devote energy developing the role of a "competent doctor," who "treats the patient as a person," which Bartlett prescribes. In other words, Bartlett describes the typical patient as skeptical of their credentials and demanding a show of competence so they will see their task as more than developing and sharpening their technical skills, i.e., "helping" the patient and not merely "learning" from her. Thus, Bartlett appears to use "passing" as a "competent" doctor as a pedagogical device with regard to his "patient as person" approach. As will be discussed, this contrasts with the pedagogical and treatment approach of the "technically oriented" residents, who also do some of the orientation lectures and first-visit pelvic examinations with the students.

Despite Bartlett's "pep talks," students (and residents) do not seem to employ his "patient as person" approach in their routine encounters with patients in the clinic. Here he complains about this "neglect" in a lecture to students.

Dr. Bartlett: "The big disadvantage of clinic care is that no one takes an interest in the patient as a person. Also, one doctor tells them one thing--another, another thing. Fairly good technical care, but on a personal basis, not so good. Anyone who is having
her first child is worried and needs and wants to talk; but everybody here is in here and out to coffee as fast as they can."

His talk implies that the students should not let themselves be "swept up" in the organizational routine wherein staff simply treat the technical problem the patient brings to the clinic so that they can limit their work day to provide ample leisure. In other words, students are to hear these complaints as referring to activities they should not be engaged in, and not merely as a criticism of the clinic's routine. He complains that this "technical approach" predominates in treatment in the clinic, with the result that staff routinely do not implement "patient as person" ideals of the medical ideology and make an effort to listen to "lay fears" and socialize patients into the medical view of childbirth as "natural, normal, and routine."

Besides the staff's concern to provide for a limited work day, another demand characteristic which makes implementing Bartlett's ideological ideals difficult for students (and residents) is the fact that a visibly competent performance on their part depends on their completion of the history and the physical examination in twenty minutes to half an hour. A "full clinic" means over forty patients will have to be seen in two hours. To meet this two hour deadline, students are expected by supervising residents to devote as little time as possible to each patient. The saliency of this time pressure in the students' outlook on their performance may be illustrated by the comments of a student to a nurse as he steps outside of a cubicle during
an examination.

Student: "Is there a lot more to go?"

Nurse: "Yes, but not a whole bunch."

Student: "It's slowing down then. I was wondering if I was taking too much time."

To further illustrate the saliency of work-load pressures in the orientation of the staff, I would like to relate the following description given me by one resident of the nurses' task back in the cubicle area: "We look to them to get rid of 'any garbage' and line up patients so the doctors make maximum use of the time." Also, if students do not deal with cases quickly, then they are often chastised for "taking so long" by the resident; and the head nurse keeps "checking" with them to ask, "Are you done yet? I need this cubicle." Also, Bartlett, himself, warns them to be quick and not try to do more than a "reasonable" examination.

Dr. Bartlett: "The complete history and physical has to be done in a reasonable time: half an hour at most. It is only sufficient to see if something is a disease, and refer her to someone else. Establish reasonable health and find the history of obstetrics and maternity. See what she needs. Get here early and get your examination done early."

The effect of this work-load pressure is that students, rather than probe patients' responses for "accuracy," or try to establish "rapport" and socialize or give advice, simply try to "get through" the interview and physical examination as quickly as possible, before Bartlett or a resident arrives to supervise the "internal" examination. As a result, the
structure of the medical history and physical examination form
guides the student's interaction with the patient. Students
try to rush patients through the various topics on the form to
fill out a complete form in the allotted time. In this regard,
Bartlett, himself emphasizes the importance of an accurate,
completed form as the primary task for students in the clinic.

Dr. Bartlett: "It used to take eight hours for a medical
student to do one patient, and do all the
tests, and the doctor would be down on you
if they didn't get done. The older order
has changed, and you have the advantages
and disadvantages of the new order; but
basically a lot hasn't changed. The trouble
in medicine is not what people don't know,
but they don't do it. Anyone can fill out
a form, but they don't do it. You've got to
develop a system and do it, if you're to
be a conscientious doctor."

This is basically a moral appeal to students to honor medicine
and their duty to its ethical tenets to persuade them not to
follow the current clinic practice of "sloppy" and "careless"
history taking. In the clinic, I found little accountability
for poor completion of forms because students work in the
clinic for only a month before moving to another Department in
the Hospital--plus the fact that all staff scribble illegibly
their signatures on the forms. Besides, staff are usually too
busy to trace and sanction the offender. Thus, it is only
through such moral appeals that Bartlett can hope to reduce
the incidence of such "carelessness." On the other hand,
while instructing students to attend to work-load demands and
competent form completion, he nevertheless reminds them that
the patient is a person with "needs" for socialization or
advice as well as "help" with her "social situation."

Dr. Bartlett: "The patient comes to us for help; and you can't just fill out forms and let them go. Often responsibility is shelved, and people stop thinking and just fill out forms. You have to tell them about their health and give them some advice."

In this regard Bartlett made the following "complaint" to me.

The students don't ask social questions and are less thorough than they should be. It's these darn forms! I want to get them at this stage (beginning of their third year); so they'll incorporate more of the social side of medicine later.

Thus, while he exerts moral pressure on students to observe ideals of the "patient as person" approach, the organizational and work exigencies, including the forms, to which he also "orients" them provide the practical contingencies setting the limits within which it may be accomplished. He presents it as a moral requirement of them as doctors to manage such "practical pressures" so as to discharge their "duty" to treat "non-technical needs," such as "teaching" patients about their "health." He sees it as important that he provide moral education early; presumably, before they become socialized and "wise" in the clinic-located "technical" approach, which defines the patient as a set of symptoms to be treated and a "medical past" to be recorded.

As Bartlett asserted earlier, it appeared that his ideologically-prescribed ideal model of the patient as a "younger sister" and his "patient as person" approach was not the everyday work-located typification of the patient, or routine approach, employed by residents and students in the
clinic. His view of the setting-specific, or "technical," approach is shared by the social worker in the intake area. She related to me the following contrast between the consultant and the residents: "Dr. Bartlett, the consultant, is especially concerned with the person; the residents only refer to the body condition in room ____." When Bartlett is not available, several residents do the orientation visit with the third year students. One of the students remarked to me on the differences between one teaching resident, Dr. Sands, and Bartlett. He suggests that staff's "technical approach" is reflected in their pedagogical technique and orientation, especially when they, as a group, treat or examine a patient. Here they have just observed while Sands inserted a fetal monitoring device into the uterus of a laboring, loudly complaining patient in the delivery room.

Student: "I characterize Dr. Sands as technically oriented. He asks a lot of technical questions of the patient. He asked a lot of technical questions of us today; even while the patient was in pain in the delivery room. Dr. Bartlett asks fewer questions. He is more concerned with communicating a bedside manner and just getting the students accustomed to clinic care. Dr. Sands asks us for a lot of numbers. He's a lab technician. What's the use of knowing all these numbers?"

Like the social worker, this student felt that residents do not deal with the "refinements" ("bedside manner") of treating patients as much as Bartlett does. Basically, staff seem more concerned with simply diagnosing, filling out forms, and treating whatever complaints the patient brought to the clinic, with
less time or effort devoted to "teaching" patients the medical ideology.

In this regard, James Henslin in his analysis of the "sociology of the pelvic examination" observes that, generally, women's outpatient clinics have been described by patients as settings where their concerns for modesty and moral respect have not been observed by medical staff, unlike private practice. Here he reports on the reactions of clinic patients in general.

Sometimes doctors are "less gentle" with such patients and "less concerned" about the patient's feelings during the examination. Henslin had this reported to him by women on welfare concerning the "coldness" and "callousness" of doctors performing vaginal examinations in public health settings, while Biggs (his co-author) has observed this same "behavior" in a public health clinic.

I am not interested in adding to the often-made invidious comparisons between clinic and private practice. Henslin's data, along with the observations of Bartlett and others in the clinic, is presented to indicate that an approach other than the ideal "patient as person" is employed by this clinic's staff, and probably in other clinics as well. Basically, it is not my intent in this thesis to "muckrake" and reveal the "deplorable truth" about this maternity service. Such criticisms can already be found in the medical and social science literature designed to "reform" or "improve" clinic and hospital care. Besides, doing this sort of irony cannot qualify as an adequate sociological analysis because it starts from value premises or standards as to what is "good, considerate care." In the literature, such yardsticks of "adequate" or
"ideal" care typically remain implicit, and probably can be applied to any treatment setting to "discover" or "analyze" patient care as "inadequate" or "careless" and, therefore, departing from those ideals. These ideal standards usually are based on the "patient as person" ideals embodied in the medical ideology, assumed to be in greater application in private practice. On the other hand, my only interest here is to treat this "patient as person" approach as itself a pedagogically located view to be described as to its features, particularly as it entails certain patient management methods. In no way do I intend to use it, as have other researchers, as a common-sense value perspective with which to construct a "theoretical approach" to "uncover" clinic routines, and thereby be able to describe the many ways that a public clinic "depersonalizes" or otherwise "abuses" the patient as a "technical" or "teaching" object, in contrast to the proprietous treatment presumed to be available in private practice. Again, I wish to make no such invidious comparisons, but instead to describe adequately the two different approaches to patient care as they reveal different techniques of patient management.

**Two Approaches to Patient Care**

As the student's remarks to me suggest, residents in their teaching concentrate on the "technical side" of the clinical visits, paying only "lip-service" to "patient as person" ideals. This focus is apparent in their orientation visits with patients. For example, here Sands lectures students
while conducting a routine check-up, where just a physical examination and an assessment of the progress of the pregnancy are performed.

Doctor: "Be sure and ask the patient the date of the last menstrual period. This could be embarrassing if she knows and you make a mistake in prediction. In the interview, ask about the most common illnesses, especially in reproductive age girls, such as hypertension, instead of heart disease. Ask about diabetes. Pregnancy will precipitate diabetes, if so . . . (to the patient) Just for a few minutes, okay? (Patient laughs nervously.) Ask about her family history. Ask about ease of previous deliveries. If it was quick, then you may have a delivery before she gets to the hospital. Economics may influence the situation as to whether a patient can come back frequently, and whether she can afford transportation. You should act as a social worker, and not treat her just as a pregnant girl. Even as a specialist you should be able to cope with any family problems. You should know when to get her to the hospital, and if she's likely to have a short labor period. (Students begin feeling the patient's abdomen for the baby's position.) It's like a chunk of meat. You know how much one pound is by feeling; so when you are on night duty at Metropolitan (hospital) feel them and watch to see how close to labor they are. The baby is usually within a pound; but it's not easy to tell. If the baby is not engaged by the third trimester, then chances of placenta previa, or fetal malpresentation, or there is an obstruction in the passageway, or a tumor on the baby. (to the patient) Just a few more minutes, okay? (Sands does not look for the patient's response to this question, nor does he wait for one, before continuing his lecture.) (He listens for the fetal heartbeat rate and says to the patient) Fine. Okay. Everything's all right."

Patient: "No sleep."

Dr.: "Do you have trouble sleeping? (He does not pursue the topic introduced by the patient.) Come back in one week. (Before the patient is formally dismissed, he continues lecturing.) If the patient gains four pounds a week find out about her dietary intake. Low income groups subsist on too much macaroni and bread.
A doctor should suggest other things that are cheap. Since she's Italian, (the patient lying on the table) she likes pasta; but she likes salads, too, so get her to substitute. Don't take it for granted. Know why she isn't eating the right things. You may have to go through the diet individually. Patients have to be guided by telling them explicitly what to do. Teenagers are hard because they like salt. So if you take something away, give something back, like a baby. Have the dietitian give her a diet she can follow. If not, have her follow a doctor's diet.

An obvious feature of this teaching method is that no attempt is made to delay or schedule didactic talk around the contact with the patient. Bartlett, on the other hand, restricted such talk mainly to the "backstage," prior or subsequent to the interview and examination. Sands' remark, "Just for a few minutes, okay?", I take it, is his attempt at "saving face" and justifying the use of the patient as a teaching object. It constitutes an "exclusion device"² whereby the patient is notified that she is not to "butt in." It serves to show the patient that she need not be a listener and, in fact, is not one. This device illustrates one method whereby a patient's conversational rights may be limited so that she may be treated as a passive object for conversation among staff. Despite the fact that Sands protests the ideologically prescribed ideal of treating patients as a social worker might, he, himself, treats this patient as only a "pregnant girl" and refers to the fetus as a "chunk of meat." Also, he does not devote any part of his talk to persuading students to observe proprieties surrounding sexual overtones and "hurting" the patient, as Bartlett does. A minimum of interaction takes place between he and the
patient, to the extent of not following up on the problem of "no sleep" which she introduces, apparently because he is concentrating more than Bartlett on the teaching function i.e., regarding patient contact as an occasion to teach and learn, primarily, rather than "help" or give advice. Also, his model of the patient seems to be that of a "baby," rather than a "younger poor sister," who needs authoritative guidance to be managed to conform to medicalized food rules. Unlike Bartlett, he does not emphasize gaining "rapport" with the "poor" patients who are nevertheless "human," as a management strategy. Rather, he provides them with ethnic and status typifications which they are to use as taken for granted resources to guide the patient to observe prenatal regimens. Such a character analysis as grounds for management to follow the diet regimen resembles that used by the head nurse and social worker in presumptively sanctioning weight gains in the waiting area of the clinic.

Earlier I asserted that clinic staff do not observe or lecture on the "courtesies" that Bartlett espouses and practices. As additional support for this generalization, I would like to consider another resident's "pep-talk," orienting students prior to their starting to do histories and examinations on their own.

Resident: "... You should do cases on your own except for the vaginal. We'll (the residents) come around and see how you are doing and do a bit of teaching. In the last group of students, one of them pressed on the clitoris with the index finger while inserting a speculum; and
we frown on that here. You are to call me, or other residents, if you have problems, then the intern, or the head nurse, if none of us are about. You'll get most of your interesting cases here, not in the ward. Most of the clinic learning will be here. There is a big variety of cases here. Some of the patients are not very intelligent and are not able to follow instructions, but you have to be patient. Also, you might have to talk down, no, not talk down, but lower yourselves so you can talk on their level. A vaginal will be done on the first visit, and as they near term, to see if the baby is all right. We do vaginals on gynecology patients as the case warrants it."

The resident seems primarily concerned with persuading students to be interested in coming down to the clinic from the wards. He does this by emphasizing the advantages of the clinic patients as teaching objects. Apparently he assumes (and uses the assumption as a pedagogical resource) that students are primarily interested in learning from the patients, not helping them, as Bartlett exhorts them to do, so he stresses this aspect of the clinic. On the other hand, unlike Bartlett, he makes only passing reference to the importance of managing sexual implications and communicating or "teaching." He only warns them against the more gross and provocative sexual activity, not with exercising interactional control to prevent sexual connotations from even arising. Also, in discussing management approaches, he shows that he shares Dr. Sands' model of the patient as a "baby" who needs authoritative guidance or "instructions." While he tries to "repair" the apparent impropriety of this view ("... no, not talk down ..."), he still makes it clear where the clinic patient stands in
relationship to the staff ("... lower yourselves so you can talk on their level.") In practice, in his routine treatment of the patients, this resident, like Sands, is less circumspect than Bartlett in preventing sexual implications from arising. These residents, themselves, for example even invited these implications by telling patients at the beginning of the pelvic examinations to "spread their legs," whereas Bartlett normally asks the patient to "let your legs fall apart" or "move your legs wider."

To further support my contention that Dr. Sands and other residents only "pay lip-service" to ideological "patient as person" ideals ("... you should be able to cope with any family problem..."), I would like to consider another teaching occasion with a patient.

Dr.: "There are two dates for her last normal menstrual period in her file: February 1 and nine. The problem with her is that four weeks' discrepancy is important. If you take the first date, she's overdue beyond 42 weeks. We would not be happy with her. If it's the second date, then fine. (to patient) What date do you think is correct?"

Patient: "I don't know because I stopped taking pills and my period was irregular."

Dr.: "So it's especially important to get the uterus size at the first visit. The description in her file is not good because it just says that the size is consistent with the February 9 date and does not give a description of the uterus. It's important to know if she's past due because you'll have to deliver her here. Due in one week, or past due."

Patient: "For one week I have had pains; but they're not regular. I know labor pains. I may be wrong on all the dates."

Dr.: "A few days wouldn't make that much difference."
(feels patient's stomach) The baby's head isn't engaged. So we'll have to do a vaginal examination to examine the cervix to see if it's ripening."

Patient: "I get pains when I go to the bathroom."

Dr.: "Do you take iron pills?"

Patient: "I have them but I have been away from home."

Dr.: "You're not sick with them?"

Patient: "No."

Dr.: "Any complaints?"

Patient: "Just these pains. They're not as strong as labor pains."

Dr.: (patient has been wearing panties) "Take off your panties. (Sands does a pelvic examination.) It's hard to tell. You probably have one or two weeks yet. But even after the baby is born, you can only tell more or less. It will tell you before what date you got pregnant."

Patient: "Can you tell the day when I got pregnant? I want to know who the father is."

Dr.: "A blood test could determine it; but it would cause a fight and litigation in court."

Patient: "My husband left on February 15; and I want to know if I could have got pregnant before then."

Dr.: "I won't say for sure. You should tell your regular Dr., Dr. G. (a resident), to take care of that when you're delivered."

Patient: "Can I bring my husband to the clinic? He has accepted the baby; but we just want to know who the father is."

Dr.: "Let the doctor do that later. We don't like to get into that much detail about the blood type."

Patient: "How can I find out about the blood type?"

Dr.: (irritated) "I don't want to take care of that now. (Afterwards I asked Sands why he did not want to go into it. He seemed "very defensive" in replying that even though the husband seems to accept it,
he's liable to start a fight before the delivery, or leave when the baby's identity is known. I just don't like to handle these matters, anyway."

Sands' remark, ". . . the description is not good. . .," may be intended as a criticism of clinic staff, but the patient may hear it as a negative diagnosis. He apparently is so involved in his lecture that he may not hear the ambiguity in his talk. This faux pas shows that he, like other residents, focuses primarily on the teaching function and treats the patient as a set of symptoms. The patient brings up her pains three times in the examination, but this is ignored, apparently because he is so busy teaching students and persuading the patient of the need to take iron pills. The patient's answer to his inquiry on whether she is taking iron shows she hears it as not merely intended to collect information, but in fact dealing with a sanctionable topic, the adherence to a medical regimen. Thus her response ". . . I have been away from home. . ." seems intended to avoid a reprimand. Neither the resident nor the students leave when the patient is "put up" in the stirrups by the nurse. Unlike Bartlett, most staff do not lecture on or observe this "courtesy." Also, his command to "take off your panties" in front of him and the students reflects the fact that clinic staff are less circumspect than the teaching consultant in avoiding or not inviting sexual implications. In an earlier lecture, Sands had told students they "should act as a social worker" and "be able to cope with any family problems," but I claimed that this was merely paying
"lip-service" to "patient as person" ideals. I believe there is in this examination an example of why my assertion is correct. Initially, he just wants to establish an estimated date of impregnation in order to do a routine calculation of her due date and evaluate the normalcy of her pregnancy. However, he cannot ascertain it for certain, so he tells the patient that she should wait until the delivery to estimate the date of impregnation. The patient, nevertheless, presses him for an estimation, explaining her motive is to resolve a "family" matter, i.e., a question of paternity. He answers that he will not do the necessary blood test of the fetus in utero because it would inevitably cause a disruption of the family. I take it that here he is using his common-sense knowledge of paternity cases to "scare" the patient. He does not first inquire into the details of her relationship to her husband and his "attitude" to the baby before predicting the outcome in her case, but instead poses a troublesome outcome as a certainty. Thus, as with those patients planning a "natural childbirth" in a non-medical setting, staff's primary concern is not with presenting the "objective" facts and probabilities of a patient's particular case, but with sanctioning and shocking them into pursuing a medically prescribed course of action. "My husband left on February 15 . . ." is the indirect way the patient admits to having sex with someone other than her husband. However, Sands already assumed this in his attempt to "scare" the patient. When the patient is
not swayed by this management approach, he claims the clinic division of labor dictates she delay her request for her "regular doctor" at delivery, with the organizational reason that a teaching group just does not like to "go into such detail." Thus, he tries to avoid the possible inference that he is simply being arbitrary or negligent by invoking the division of labor and thereby claiming she has just asked the wrong doctor. Immediately afterwards, he admits he just does not like to handle these sort of family matters. Thus, I assert that this treatment of the patient's request for a paternity determination supports my view that he only "pays lip-service" to ideals of the "patient as person" approach, rather than dealing with "family matters," as he exhorted students in his orientation lecture.

Another example of the clinic staff's approach to the patient as a "technical object" may be found in their lack of "team discipline" when they voice differences of opinion about the disposition of a patient's case in front of her. Apparently, they are accustomed to monitoring each other's cases while in the cubicle and offering advice to each other. They are used to a great deal of consultation as part of their learning experience with the patient. On the other hand, the more experienced teaching consultant, Bartlett, usually restricts talk to the backstage before or after the contact with the patient; plus, with his experience, he seldom consults with the more junior staff.
In the following instance, one of the residents sticks his head between the curtains of the cubicle while Bartlett is doing a pelvic examination. The resident offers his advice on the advisability of doing the pelvic at this visit with this particular patient, reflecting the general clinic view of only examining and treating patients as it is absolutely necessary in order to reduce the amount of time spent with each patient. To this end they establish "rules of thumb" of when to do "pelvics." In this case, the resident tries to provide for the most efficient use of time by reminding Bartlett of such a "rule."

Resident: "There is no point in doing a pelvic at this stage in the game. There's no point in doing this examination so early--seven days after missing her period."

Dr. B.: "John, it makes for a good comparison on the next visit, as one way to test for pregnancy by looking at the size of the uterus."

Patient: (giggles) "I feel like a guinea pig!"

Resident: "An examination at 37 weeks is okay."

Dr. B.: (quietly, but very annoyed) "Let's not argue in front of the patient." (He turns away from the resident, and continues the examination.)

Evidently, Bartlett is engaged in a more time-consuming method of determining pregnancy with which the resident is not familiar. Bartlett tries to teach him the technical purpose of this approach, which is more thorough than the clinic's; but the resident persists in advocating the clinic rule of thumb despite the patient's complaint of being used as an object for teaching or research. Bartlett then cuts off the
argument by sanctioning the resident for a lack of "team discipline" in questioning his treatment of the patient in front of her. I infer that Bartlett is more sensitive to the ideologically prescribed importance of a mutual support of the appearance of a competent performance and not treating the patient, who presumably came for help, as a teaching or research object.

Also, such consultations or debates in front of the patient are a source of faux pas because staff concentrate on learning from each other, ignoring the implications of their talk for the patient, who may be overhearing. As a result, the patient may detect "troubles" with her case or sexual implications which may alarm or insult her. In the following example, the two residents are concentrating on a discussion of the disposition of a case of a patient who has discovered she is pregnant and desires an abortion.

Resident: (to patient) "Take a few breaths in and out." (He is trying to get the patient to relax while attempting to do a pelvic examination. A resident comes into the cubicle and he says to him) "The girl is petrified to be examined. November 9 was her last period. In January we did a vaginal and found the uterus swollen. We did a positive (pregnancy) test; and that didn't excite her at all; and she's still pregnant. I met the guy last time (the patient's boy friend). He seemed like a reasonable guy; but he can't seem to get a job. I think he's exploiting her. (to the patient) How do you feel about the baby?"

Patient: "I want to get rid of it."

This practice contrasts with that of Bartlett who, when he encounters a patient who is "too tense" to be examined, does
not mention this to the students in front of the patient, but waits until they step outside the cubicle while the patient is being "put up" to discuss the patient's troubles with them. The resident's remarks about the boy friend could insult the patient and make her less cooperative.

**Moral Control and Experience**

The clinic staff's "technical approach" may stem not only from their concern to learn from patients, work-load pressures, and an interest in limiting the work day, but also from a lack of experience in "handling" patients, and less familiarity than consulting obstetricians (like Bartlett) with the professional literature on implementing ideals of "patient-centered" medicine. This assertion is supported by Dr. Bartlett's view of the residents' competency, as well as the fact that the junior residents usually call for the chief resident when patients confront them with "social" or "family" matters, such as paternity determination and "sex counseling."

Here Bartlett relates to me the relative experience and competency of the residents.

Dr. B.: "B. P., H., and Sands are all second-year residents. The third year resident is Chief Resident Carls. He's more experienced than much of the staff and knows most of the literature. The rest are weak on experience and are not sure of themselves."

The following is an example of where Carls is brought in by a resident to deal with a "family problem," determination of paternity. Unlike Sands, he does not try to avoid dealing with such a case, but instead tries to advise the patient on
how to deal with her husband and agrees to provide a blood test.

Patient: (crying) "My husband is cheating on me because he suspects the baby is not his."

Dr.: "When did you last have intercourse with him?"

Patient: "I've never cheated."

Dr.: "It's too early in the pregnancy to get a fetal blood type. Come back and go to the second floor. Your husband won't hit you, will he? Don't let your husband ride you! I suppose you are clean?"

Patient: "Yes."

Carl's infers that the patient is requesting information as to the baby's paternity and tries to get information as to her "sex life" in order to "help" her. However, the patient treats his question as "none of his business" and having non-medical implications, i.e., that the doctor wants to question her fidelity and not merely gather information as to paternity. In fact, his question has relevance only if she has had intercourse with someone else. Consequently, she protests her innocence. His advice to the patient to not let her husband "ride her" presumably constitutes a "pep-talk," where he tries to influence her to "straighten out" her husband. His question on whether her husband will hit her and the subsequent "pep-talk" seem based on the doctor's assumption about "normal trouble" in paternity cases, since the patient only mentioned that her husband was unfaithful. On the other hand, his final question ("I suppose you are clean?") shows he is not totally convinced by her protest of innocence. He seems to be advising
the patient, as well, to be sure she is faithful to her husband and not lying about the paternity of the baby. Thus, unlike the other residents, he not only offers to provide a blood test, but tries to directly intercede in the "family problem" by giving a "pep-talk" and reminding the patient of her moral responsibility as a "good" mother-to-be.

Further support that a lack of experience and familiarity with the professional medical literature on "patient-centered care" contribute to the employment of a "technical approach" may be found in a description of a clinic routine provided by an experienced obstetrician. In the following depiction, the writer, Dr. William Sweeney, III, a forty-nine year old New York teaching consultant, makes it clear that he tries to implement the "patient as person" approach in his practice and espouses it in "pep-talks" to his students, as well as subscribes to a "negative" view of clinic staff, as did Bartlett.

I think those women who go to Infertility Clinic are in some ways the most courageous people I know. I always tell the medical students that the clinic patient with a gynecological or obstetrical problem is very special. She probably doesn't have enough money to go to a private doctor, but she's no less sensitive about intimate things than anyone else. So she comes to the great hospital and she expects a gray-haired kindly old doctor is going to see her. What happens? First she's herded into a waiting room filled with other women and moved around. Finally, when it's her turn to have her history taken, who comes in but this bright-eyed, bushy-tailed little medical student. Now that's her first real contact with the hospital and she's shocked. I mean, she expected a distinguished fifty-year-old man and she got what she thinks is a twelve-year-old boy asking her when she last made love. I don't know how she answers any of the questions.
Especially if this idiot sits down and says, "Okay, now let's go to work, when did you last have intercourse?" Or, "When was your last menstrual period?"

I think if I were that woman I'd either get up and leave or I'd slap his little face or spank his behind. But if she can stomach the young doctor's unintentional crudeness, she's whisked into a small room and told to get undressed.

Then she's put in the most ungodly position in the world with her legs spread apart, and in bounces this same little boy, accompanied by a nurse who looks like she's twelve and a half and never had a period in her life. Together they futz around and then they probably say, "Well, now we're going to have the older doctor examine you." And who walks in? A resident doctor, age thirty, or a young attending, age forty, both with hair down around their shoulders. She still hasn't got the gray-haired kindly old doctor she was looking for.

So clinics are difficult for patients, even though technically a woman probably gets the best medical care in the world at the clinic of a good teaching hospital. . . .

But scientific care and knowledge aren't all a patient needs. There's an art to medicine that the young clinic doctors are lacking. The intern or resident is taught what questions to ask, but not how to ask them. He doesn't have to sit down and say, "Okay, now let's go to work. . . ." He can talk a little bit first. "How are things? Is it still raining?" Anything to break the ice. Or, especially in a crowded clinic, "There are some things we have to know in order to take care of you, but I'm sure we can keep our voices down so everybody doesn't have to hear us."

I can remember one resident at Infertility Clinic saying, "Now I want you to have intercourse at 2 p.m. and then come straight in here by two forty-five. . . ." After the woman left, I said, "What do you mean, you want her to do this and that? Don't you agree it sounds nicer to say, "If it is possible for you to have intercourse at two, could you be here about two forty-five?"

But none of this stops the woman who really wants to get pregnant. She'll willingly go through all the tests we make before we get around to the post-coital test. (of the husband's sperm)

Once we're ready to do the post-coital test, these women
have to go home and have intercourse that is not love-making. It's just plain, "Lie down and have intercourse on the twelfth, fourteenth and sixteenth days, dear, because Dr. Sweeney says we have to."

And a lot of husbands really can't do that. I always tell my ladies to go home and use their feminine wiles. "Don't ever say, 'We have to do such and such for Dr. Sweeney.' You can con him." So it's the twelfth, fourteenth and sixteenth and he doesn't know what's happening; he's having intercourse but he's making love. The wife is just having intercourse because she's thinking about the dates and the reason, but he can be had. There's more to fertility than screwing, let's face it.

I infer from what Sweeney tells his students that he shares with Bartlett the ideologically prescribed model of the clinic patient as a "poor sister," who has certain expectations about medical personnel as well as concerns for modesty and a romantic view of sexual intercourse. He contends that students and young doctors do not really "pass" as competent doctors with the typical "clinic patients." He implies that this alone presents an obstacle to having the patient frankly divulge her "private life." Youthful doctors compound this difficulty by asking questions in a "crude" manner. They ask these "crude questions" because they are not experienced enough and trained to attend to patient "needs" beyond that covered by "scientific care and knowledge." He claims they lack the training and experience to ask "intimate" questions in an "artful" manner, e.g., by first establishing a state of talk via small talk, or prefacing the question with assurances that he will be circumspect, and thus take into account the obvious public character of the clinic. His criticisms of the New York clinic recalls Bartlett's depiction of the City clinic.
("... that farm ..."), where matters of privacy and modesty are "being tramped on all the time." Sweeney tries to teach a resident to implement his approach of persuading the patient to be cooperative in following instructions, which reflects his ideal model of the patient as being "very special," deserving of "respect" and "politeness." On the other hand, staff's approach in the New York clinic compares with Sands admonitions to the students at City that, like a baby, patients have to be authoritatively guided by telling them explicitly what to do. Apparently, Sweeney would go beyond being polite (in an effort to control patients' sex lives) and try to actively intercede by encouraging the patient to deceive her spouse by casting a "medical activity" (sexual intercourse to collect a sperm sample) in a romantic guise.

Like Sweeney, I found generally that the older doctors differed from the "raw recruit" students and young residents not so much in technical skills and knowledge, but in skills in exercising more control over the patient. For example, when the students dealt with the patient, there were more chances for equal conversational exchanges, whereas, older doctors like Bartlett and Carls tightly managed interaction so patients were not treated as an equal co-participant in talk. With younger doctors and patients, there was more "give and take," with more opportunities for the patient to introduce sexual and moral overtones. I observed an example in the clinic of how this "give and take" in conversation results in disruptive
incidents. Also, this incident shows how, as in the New York Infertility Clinic, younger staff may provoke moral reactions in patients by their "artless" questions which invite moral sexual implications. Here a student tries to manage a "reluctant" patient in the interview and examination.

Patient: "I haven't had a period for three months. I'm either sick or pregnant."

Student: "Either way you should be here."

Patient: "My period wasn't regular last year. It ranges from 21 to 36 days. I hate pills. I took them four months last year."

Student: "Have you had intercourse regularly?"

Patient: "Yeah. I'm married. Ha! Ha!"

Student: "Well . . . I see so many people during the day. It may seem funny, but it's important. You're not taking pills, so you've been trying to get pregnant in other words. How's your appetite?"

Patient: "Shit. It's gone completely. I feel bad in the morning."

Student: "Do your breasts turn darker or swell, or become sore?"

Patient: "My breasts have always been sore, but I don't notice any pain in my breast, so I guess not."

Student: "I'll have to get a book to see what all this means. . . ."

Despite Bartlett's "pep-talks" on "passing devices," this student did not try to artfully dodge the patient's implied question about her breasts "always being painful," and thereby try to gloss his ignorance. His question, "have you had intercourse regularly?", invites moral and sexual implications. Typically, senior doctors pose it in a less "risky" manner; "Frankly tell the doctor when you've had intercourse" or,
"How often do you have sex?" This approach provides less opportunity for the patient to treat these "intimate" questions morally in formulating her responses. It presumes that the patient does have sex routinely as part of being married, as opposed to the student's formulation which invites the moral interpretation that the student wants to inquire as to the normalcy of the patient's sex life and, by implication, her marriage. An unmarried patient may detect implications of promiscuity, or "abnormal" sexual appetite. I take it that her response, "I'm married," is intended to prevent the student from seeing her as "abnormally" sexed. His techniques of formulating questions provide a target for the patient's moral views. It offers an opening in which the patient can display her belief that they (his questions) constitute an unwarranted invasion of privacy and are motivated by suspected prurient interests; i.e., she explicitly disavows the purely technical character of such questions, and suggests that she sees them as dealing with shameful and "dirty" matters. She organizes her response so it falls within the accepted proprieties; i.e., she does not say she has sex a lot, but instead, makes it clear that her rate of intercourse falls within the range of morally acceptable behavior. As Bartlett mentions in his lectures, as a result of this process, the patient shapes the information given in the interview. On his part, he apologetically accepts the patient's sanctioning of his question. Normally, older staff would ignore sexual and moral implications, introduced by her as a commonly used management
technique to control the interaction by trying to prevent them from becoming topics for a "give and take" conversation. The student reveals his inexperience in this response by "crudely" displaying the normative outlook on the proprieties of marriage: (he implies) "Sorry I asked; I know marriage has regulations and should be the rock on which society is based."

"You're not taking pills, so you've been trying to get pregnant, in other words?" shows that the student took cognizance of her earlier remark about having stopped taking pills and takes this as signifying that she has been deliberately seeking to get pregnant. He seems, thereby, to make visible the medical view that conception is "naturally" a matter for "rational" planning. Thus, although probably inadvertently, he is indirectly advising the patient on this prescribed approach to conception—whereas she treats birth control as a matter of personal taste, to be used or not depending on whether she likes or "hates" it.

As further support for my analysis, I would like to refer to Joan Emerson's study of pelvic examinations performed in the gynecological ward of a medical school. She points out that the patient in the examination is the most frequent source of explicit sexual connotations, which implies one important cross-cultural feature of the pelvic examination and interview; i. e., patients often treat them as having obvious sexual implications, as opposed to staff who typically try to persuade the patient to treat them as non-sexual events. However, she
also implies that experience plays a large part in determining the frequency with which staff, themselves, introduce sexual overtones into the interaction, and thereby fail to implement the ideals of the "patient as person" ideology advocated and practiced by the older, more experienced staff.

Precariousness in Gynecological Examinations

Threats to the (non-sexual—J.E.F.) reality of a gynecological examination may occur if the balance of opposing definitions (medical versus lay—J.E.F.) is not maintained as described above. Reality in gynecological examinations is challenged mainly by patients. Occasionally a medical student, who might be considerably more of a novice than an experienced patient, seemed uncomfortable in the scene. Experienced staff members were rarely observed to undermine the reality.5

In the above example at City, I pointed out how the younger staff do not ignore sexual and moral overtones introduced by patients as frequently as did the Chief Resident and the teaching obstetrician. Instead, they often engaged in conversational exchanges wherein they join the patient in explicitly acknowledging these implications. Similarly, when a "reluctant" patient protests about being examined, thereby introducing sexual implications, they, themselves, may introduce sexual and moral overtones in their attempts to persuade the patient to cooperate and not treat it as a matter for modesty. In addition, they may try to coerce or cajole her to try to persuade her to forego her "sensitiveness." Emerson's study provides support for these observations at City in the following example. Here a black nurse is putting a gown on
a married black patient in preparation for the arrival of the
doctor and the pelvic examination.

Nurse: "I didn't mean for you to be exposed, your
shape and all."

Patient: "Oh, that's okay. I have such a beautiful
one. /joke/ I had two at once giving me shots.
/joke/ When I came to the clinic, I was doing
all right until they got down to--and I said,
'you going to examine me down there/' He said,
'Aren't you married?'" /humor/

Nurse: (laughs) "I'm ashamed of you." /joke/

Patient: "I don't like that sort of thing. He was a
young doctor, too."6

The young doctor uses a sanction which invites sexual implica-
tions and the patient apparently found him insulting. He
already knows she is married and uses her status as grounds for
claiming she has no right to protest. In so doing, he implies
that marriage requires the patient to allow a male to "take
liberties" and violate proprieties of modesty. He implies
that, since this is so, she foregoes the right to demand that
these proprieties be observed when other males in a medical
setting wish to violate them. Thus, he invites the insulting
implication that married patients are no longer entitled to
have these proprieties honored. The attending nurse had
politely and flatteringly shown concern for these proprieties
by draping the patient before the doctor's arrival. However,
she adds her own mild chastisement ("I'm ashamed of you") to
the doctor's sanction. I infer this to be an instance of the
kind of "team work" that routinely goes on whereby staff
support each other's attempts to manage a "reluctant" patient.

As I have mentioned, younger staff at City also try to manage the sexual overtones introduced by the protests of a "reluctant" patient by coercing and cajoling her. In the following example, a student treats a patient's gasp as constituting such a protest.

Student: "What makes you think you are pregnant?"

Patient: "A lump in my stomach. Maybe there's something wrong with me. It could be cancer; and besides I've been having periods. Or, Heart disease. I have a cousin with a hole in the heart."

Student: (ignoring the remark about heart disease) "Oh, okay. I'll bet it's not cancer; so I better take a look down there. (the patient gasps) That's what you sign up for when you come here. It's not bad when it's done carefully. Are you game? You've never had an exam before? (the patient shakes her head; and the nurse proceeds to "put her up" on the stirrups)

"I'll bet it is not cancer . . . ." stands as his effort to provide a medical warrant or pretext to do the examination since, even when cancer is not suspected, it is routinely performed. Next, he shows that he assumes the cross-cultural character of the examination by "filling in," or inferring a protest when she gasps. "That's what you signed up for . . . ." appears to be an "ecological device" similar to that employed in military training camps where the "reluctant" recruit is rhetorically coerced to cooperate on the grounds that, "You're in the Army now." In other words, the patient must accept this "care" since, whether she knew it or not, she agreed to it when she signed the "consent to care" form at the receptionist's
desk on arriving at the clinic. He implies she has no legitimate grounds to protest or refuse because she, herself, already agreed to be examined just by coming to the clinic for care. Following this management effort, he seems to redefine her apparent protest of embarrassment as being merely fear of a painful examination at his hands. As a result, he presumptuously and indirectly protests his competence by speaking in the abstract ("It's not bad when it's done carefully.") In other words, while he does not directly "advertise for himself," he makes an abstract, general formulation which presumably the patient is to hear as applying to her case. After this oblique self-defense he tries to cajole her by offering a "sporting challenge" ("Are you game?"). This management technique is similar to the process of "sounding" in juvenile gangs whereby members try to persuade one another to engage in "anti-social" activities by "daring" each other to show that they are not "chicken." Finally, the patient allows herself to be "put up" without protest, other than the gasp which he treated as a protest warranting management efforts. Thus, as in Emerson's study, this student displays his inexperience by quickly endeavoring to deprive her of legitimate grounds to refuse or protest. Instead of invoking her marital status, (as in that study) he uses an ecological device, tries to redefine her "protest," and then tries to cajole her.

In contrast to these methods, older, more experienced doctors at City usually simply try to ignore such protests
or else try to redefine them as merely a concern to know the medical purpose of the examination, which may be more easily dealt with without acknowledging moral or sexual overtones. Again, Emerson's data may be cited to support my observations at City.

Patient: "You're not going to feel me, are you, Dr. Raleigh?"

Dr.: "I'm going to examine you to find out what's going on." (The patient protests this a little and Dr. R. keeps insisting. Mrs. Biggs (the patient) talks a great deal during the examination on the subject of the examination.)

Patient: "If you'd been poked in as many times as I have, been hurt as many times as I have--it's terrible."

Dr.: "Yes, I know."

Patient: "Oh, Dr. Raleigh, what are you doing?"

Dr.: (exaggerating his southern accent) "Nothin'."

Patient: "Well, you are, too."

Dr.: "I'm just cleaning out some blood clots."

Miss Nero: (the nurse) "He's just trying to fix you up a bit, Mrs. Biggs."

Patient: "Are you through yet...?"

Here we see an instance of the commonly used techniques of "teaching" the patient the "medical purpose" for her discomfort and the objectionable treatment being administered. ("I'm going to examine you to see what's going on."

"Just cleaning out some blood clots."

"Just trying to fix you up a bit.")

In so doing, staff seldom provide a technically complete or accurate picture of what they are doing or why they are
treatment her. Usually, this "teaching" involves some vague, general, euphemistic description which, presumably, the patient would understand. They try to avoid using technical terms and graphic details which they assume would further alarm or anger the patient. In any event, this method's essential purpose is not to keep the patient informed so she can give "informed consent" to the treatment as it is administered, but rather to persuade her to accept the "medical fact" that it is in some way "required," yet does not involve "serious trouble" in her case.

Besides protesting the examination itself, patients at City may introduce sexual overtones in expressing disapproval of the attendance of more than one "doctor" when several students try to "practice" on a patient without the supervision of Bartlett or a resident, who usually do not want to be present until the pelvic examination. The students are often at a loss for words to respond to such a protest of embarrassment, allowing the patient's sanction to stand while proceeding to do the interview and physical examination. When they do manage to make some reply, they often introduce sexual overtones or implications of pain similar to their attempts to manage a "reluctant" patient as discussed above. In any event, regardless of students' management efforts, or lack of them, in subsequent interaction in the interview and physical examination, patients often make it clear that they regard them as peers without the conversational rights and privileges usually granted a doctor vis-a-vis a patient; e.g., in the
tightly structured interview a patient may feel free to question students, in turn, on topics on which she is being queried. Also, as a result, she may treat their questions and subsequent examination as a "game" wherein the students are not to be taken seriously since they are peers "playing at medicine." While usually allowing them to do the interview and physical examination, the patient may, in some cases, persistently refuse to allow them to perform the pelvic examination, insisting on the services of a "real" doctor. The following is an example at City of how students may be dumbfounded when a patient protests the large number (four) by pointing out how it provokes embarrassment in her.

(Four students come into the cubicle)
Patient: "Are you all students?"
Student: "Yes."
Patient: "Don't you know it makes a patient nervous to have all these people around her?" (Students do not reply.) "Oh, you are probably used to hospital surroundings!"
Student: "How are you feeling?"
Patient: "Okay, I guess." (The student asks about past diseases in the family and then about her past drug use.)
Student: "Do you use drugs?"
Patient: "I smoke hash; but I don't use any needles."
Student: "Do you use L.S.D.?"
Patient: "I haven't used it lately. Do you turn on, Doctor?"
(The student does not reply.)
Patient: "I don't expect you to say." (He takes her blood pressure.) "Is my blood pressure normal?"

Student: "Yes."

Once the patient has ascertained their lack of credentials, she scolds them for violating her privacy. In the process, she categorizes them as mere "people," implying she sees them as lacking credentials or special expertise, distinguishing them from lay peers. When the students are unable to reply, she apparently takes their silence for incomprehension of her concerns and chastises them by accusing them of being so accustomed to events in the hospital having a strictly technical or medical significance (i.e., using a "technical" approach) that they inconsiderately ignore how these same events may appear differently to the lay patient, making them "nervous."

However, again the students are unable to muster a reply to persuade the patient to accept their large number. In the subsequent interview, she proceeds to show that she regards them as peers by acting as if she has equal conversational rights with them to ask and answer questions. Her reciprocal question about his use of L.S.D., for example, is presumptuous in the sense that she has the right to ask questions of the "doctors" on the same matters on which she is being interviewed, regardless of their moral or sexual implications. Ordinarily, patients in their interaction with "real" doctors observe the proprieties governing who can ask what sort of questions and legitimately expect an answer; i.e., such rights are regarded as not symmetrical or equal. In fact, one way of making an
insult is for the patient to ignore these proprieties and ask reciprocal questions of the doctor, particularly of a moral or sexual nature. When the student does not reply to her question on L.S.D., she then implies that she was "out of place" as a patient in acting as if there were reciprocal or symmetrical rights to ask "personal" or "medical" questions by explicitly acknowledging that she did not expect them to treat her "moral" question as requiring an answer. By apologetically acknowledging that she has violated these proprieties she shows she is cognizant of them.

Another pelvic examination observed at City illustrates how students may employ "crude" humor to reply to a patient's protest at their large number and thereby themselves introduce overtones of pain and embarrassment. In this case the patient's refusal to be "internally" examined by them apparently is honored by them. However, the patient proceeds to treat the interview and physical examination as a "game" where the students are treated as peers merely "playing at doctoring." She displays the cross-cultural character of the interview, also, by treating their clumsily formulated "medical" and "personal" questions as having moral and sexual connotations, or as just irrelevant. I want to present this initial obstetrical visit in its entirety because it illustrates many of the features of the younger staff's "technical approach" to patient care and management which I discussed earlier.
(Three students enter the cubicle.)

Student: "Hi."

Patient: "Hi. Oh! Why do you need so many of you?"

Student: "To hold you down if you get rough! Ha! Ha! Have you had heart trouble?"

Patient: "Ha! Ha! I haven't eaten for two months and I get severe hunger pangs. I don't eat now because I have no money."

Student: "Do you have high blood pressure?"

Patient: "No, whatever that is. I get headaches all the time."

Student: "How long have you had these?"

Patient: "Why do they always ask that?" (irritated) "I get nightmares if that means anything. My doctor says I had kidney trouble, then says I don't. I don't know. I have had my eye muscles loosened, but that was when I was twelve. It doesn't matter." (She asks each student in turn if he is a doctor and each says 'No, I'm a student.') "Not one of you is a doctor and I'm not going to let you examine me."

Student: "Is there a cleft palate in the family or congenital diseases?"

Patient: "Ha! Ha! You mean they look funny? Ha! Ha! No."

Student: "Anything else interesting in the family?"

Patient: "Ha! Ha!"

Student: "Why do you laugh?"

Patient: "My sister had bad nerves and there is alcoholism in the family. But don't worry about it. It hasn't touched me. I'm certain I'm pregnant. You know when they asked me when I started having periods? I never counted the days of the period, but it's irregular by three days, I think."

Student: "Do you think there is anything abnormal about your flow?"
"No, I never gave it much thought."

"I wish I had a desk to write on."

"Ha! Ha! Why don't you use my stomach? If you go three months, can you have a tubular pregnancy?"

(ignores her question) "How's your appetite?"

"I'm hungry, but it's my fault. Why don't you ask about my pains?"

"I'll ask the questions, you answer. I am the, quote, doctor on everything." (He feels her breasts and asks if they are tender, but receives no answer. Then he feels her stomach.) "Are there any other pains?"

"Does it matter if I had an infection last month?" "Trichomonas started again today. I have these sharp pains." (She pulls up her legs and winces, but the student continues asking questions anyway.) "They come off and on all at once."

"Have you felt the baby?"

(Holds her thumbs up and finally answers) "I can't feel it, but there is one."

"It's too early. Can I check your chest?" (with a stethoscope)

"Ha! Ha! Ha!"

(irritated) "Do you want us to send for the other doctor (Bartlett)? You objected to us."

"Oh, it's all right as long as the doctor sees me eventually. I'm not going to let you examine me (vaginally)." (The student begins doing the physical examination.) "What kind of doctor are you going to be? I don't see how you can examine people."

"Why?"

"I'd be too embarrassed. You're very patient. You'll be a very patient doctor. When you touch my stomach I usually get quite violent."
Student: "You wouldn't do that, would you?" (He examines her feet.)

Patient: "You're feeling the bone."

Student: "You're afraid that I don't know what I am doing?"

Patient: "No, it hurts."

Student: "I get very violent when patients don't cooperate."

Patient: "I've got pelvic pain. You can note that in your records. You never socked me before? My doctor is in the Northside of the City, but I don't have the money to make the trip there, so I come to the clinic. The woman at the desk (the receptionist) doesn't like me jumping from the doctor to the clinic. I told her that I might have a miscarriage if I go to the Northside and she let me be examined here. (sarcastically) I love to be examined. I've been in the hospital earlier. I only had one donut to eat today."

Student: "You live on MacDonald hamburgers?"

Patient: "I was being sarcastic. I'm not really having trouble with the kid, just these pains. It must be constipation, because it feels solid in back." (The nurse comes into the cubicle and begins putting her up in the stirrups preparatory to the pelvic examination.) "Don't put me up on stirrups! Ha! Ha! I feel embarrassed! I'm not a good judge of doctors. You think I imagine everything."

Student: "I didn't say that!"

Patient: "Most doctors think I'm imagining." (Bartlett enters the cubicle and uses a firm tone of voice with the patient.)

Dr. B.: "Just answer my questions. First, when I point out further pains. (Touches her back and abdomen.) You're determined to keep the baby? (She's unwed.) (No answer.) You're not sure of your dates (of conception)? (No answer, and he begins doing the pelvic examination.) Let your knees relax."
Patient: "Oh! But I can't tell you, because you didn't ask."

Dr. B.: "What?"

Patient: "It's been really itchy and sore down there. I can't stand this! Ow! You're not going to stick that silver thing in me?" (The speculum, an instrument shaped like a double shoe horn to expand to diameter of the vaginal canal, so it may be examined.) "Am I all right?"

Dr. B.: "We're going to check the things you tell us about."

Patient: "This darn shoe horn! Can you see the baby?"

Dr. B.: "No."

Patient: "Are you going to stick . . . If I was carrying it low, could you tell?"

Dr. B.: "Yes."

Patient: "Does it matter that I have a small uterus? That's what the other doctor told me."

Dr. B.: "No." (to the students) "It's blue."

Patient: "Why is it blue? That hurts! What does it mean?"

Dr. B.: "Infected." (She pulls her arms up and gasps.) "Let your muscle go or it'll hurt more."

Patient: "I'm very big? Big enough for a baby?"

Dr. B.: "Yes. What size baby do you want?"

Patient: "Just normal size." (Bartlett tells the students in medical jargon the symptoms of her infection.) "What are you saying?"

Dr. B.: "We're talking doctor talk. It's nothing bad. You're normal." (She gasps and moans.) (A student begins practicing a rectal examination.)

Patient: "Hey! I'm constipated, you know. Does he have to do this, too?"

Dr. B.: "Yes. We check each other out."
Patient: (to the other students who are observing) "No way you're going to examine me too!" (As the student probes her rectum with his fingers) "You're not going to examine my rectum! Can you feel how big I am? I think I'm having a bowel movement! Push the light back, it's too hot!" (A large lamp is positioned close to the genital area routinely.) (After the student begins the rectal examination, Bartlett leaves the cubicle. When the examination is completed, she sits up.) "I can go now."

Student: "No. The doctor (Bartlett) might want to see you." (Bartlett returns.)

Dr. B.: "You have the normal pains of childbirth and stretching."

Patient: "How along am I?"

Dr. B.: "Three or four months."

Patient: "No, I'm not. I can't be."

Dr. B.: "Why can't you be?"

Patient: "My doctor says three months."

Dr. B.: "It doesn't matter."

Patient: "It matters to me."

Dr. B.: "Your pregnancy is normal, but at this point you get big fast. I'll give you a prescription for iron pills."

Patient: "I've taken them before."

Dr. B.: "How long did you take them?"

Patient: "One month, like they said."

Dr. B.: "Why did you quit?"

Patient: "I just did."

Dr. B.: "Why?"

Patient: "I didn't want to take them anymore."

Initially, the student does not treat her challenge to their
numbers seriously, introducing overtones of sex and pain in his humorous reply ("To hold you down if you get rough."). "Have you had heart trouble?", like most questions in the interview, presumably this is intended to be heard by the patient as meaning not that she, personally, is competent to diagnose this, but that she is to "fill in" the intended meaning that she has been professionally diagnosed as having heart trouble in the past. This is the sort of conversational competence on the part of the patient which staff routinely assume and use as a resource to ask questions and have them heard as part of a medical interview. On their part, patients typically do display this competence by not asking for clarification, but just providing a recordable answer to "medical" questions. I take it that she laughs at this question about heart trouble because she sees it as irrelevant for her since she is only twenty years old. Despite this lack of substantive response, the student does not repeat his question to get a clear positive or negative answer but, instead records on the medical history form that she has not had this trouble. Thus, he treats her laughter as a recordable answer. This lack of probing for a definitive answer may be accounted for by the fact that the student is trying to fill out the medical history form as completely as possible in the allotted time (fifteen minutes) before Bartlett's arrival to supervise the pelvic examination. Similarly, she complains about her eating habits and poor economic circumstance, but students ignore this problem. Again,
this may be accounted for, as Bartlett described, in terms of
time pressure and the inexperienced students using those "darn
forms" to structure their interaction with a patient. Another
feature which may contribute to this treatment is the fact that
the patient is acting "smart" and laughing at his questions.
Likewise, when the patient responds to the question on high
blood pressure by saying "No, whatever that is.", the student
nevertheless treats this as a recordable answer and writes
"No" on the form. When the student tries to historicize the
topic of her headaches ("How long have you had these?")
becomes irritated. She takes it as representative of the kind
of questions which she has been asked at medical interviews,
\textit{i. e.}, dealing with her "medical" past ("Why do they always
ask that?"). She implies that such "historical" questions are
irrelevant and bore her. Her remarks on past nightmares,
kidney trouble, and eye problems seem intended as sarcasm
("... if that means anything."), deriding the medical pre-
occupation with the past as being trivial and irrelevant to her
present health.

After "putting up" with these early "irrelevant"
questions ("It doesn't matter.") she becomes irritated and
interrupts the interview to check on the credentials of the
students as doctors. She then makes it clear that she will
only accept an M.D. bearer as entitled to perform the pelvic
examination. She seems angered by the fact that they are not
doctors, and appears to resent the threatened sexual access
by them, her peers. On their part, they do not try to argue with her on this point and appear intimidated by her refusal. Next, she treats the question about congenital disease as a joke, explicitly introducing the moral implications of the question. At the same time, she shows she competently heard the intent of the question by clearly answering, "No." The students ignore this "wise crack." Following this sequence, he clumsily formulates a vague, general question about the family's medical history ("Anything else interesting in the family?"), which invites the introduction of moral and sexual implications by the patient, who laughs. Because of the question's sexual and moral connotations, the interviewer could be asking for any family scandal which the patient can recall. However, the student, himself, appears unaware of these implications and sanctions her response as being problematic and inappropriate, as if she is "crazy" or a "screwball." Nevertheless, the patient's next utterances show she has competently heard the meaning of "interesting" in the intended way by providing the "medical facts." On the other hand, here she is presumptuous in instructing him as to the relevance of these "facts" to her current health. Again, she implies that interview questions are irrelevant and trivial because they deal with the past. In response to the question about her menstrual flow, she shows her boredom and irritation, while implying that her "No, I never gave it much thought" reflects her own assessment, rather than a past professional diagnosis. Nevertheless, the student treats this, too, as a recordable answer. His
"studentish" complaint about a lack of desk provides an opening for the patient to interject a sexual overtone ("Why don't you use my stomach?"). Also, her ("Why don't you ask about my pains?") shows her impatience with his methodical series of questions based on the interview protocol. However, he is quick to "put her in her place" by sanctioning her for presumptuously violating proprieties governing the conversational rights between a doctor and patient. He reminds her of the lack of symmetry or reciprocality on who can legitimately ask questions and expect to have them answered. He asserts that he, the "doctor," selects the topics for questioning and the patient should be passive in this activity. ("I'll ask the questions, you answer. I am the, quote, doctor on everything.") He protests his prerogatives as a "doctor," while earlier admitting he was a student. Apparently, instructing a patient in this manner as to the prescribed conversational proprieties may be particularly important for staff in the clinic, since they must control what topics are discussed in order to cover all the subjects in the interview protocol in the limited time available. Thus, limiting a patient's rights to ask questions may be an important resource in competently performing the interview and expediting the heavy workload, although it may result in a "technical approach" to patient care. However, the patient persists in trying to wrest control from him over what "problems" will be discussed by directly suggesting her present trouble as a topic and making a sarcastic preface to
the topic which challenges him to consider it ("Why don't you ask about my pains?" "Does it matter if I had an infection last month?"). Later in the interaction she even tries to get their attention to her present complaint by the device of phrasing it as a matter for their records, apparently because she observes that they seem more concerned with asking a variety of questions to get a "complete record" than simply finding out what troubles her currently and treating it ("I've got pelvic pain. You can note that in your records."). However, the student still does not pursue the topics she suggests and continues to follow the protocol. Finally, after having her complaints consistently ignored, she accuses them of treating her as a crazy or hypochondriacal person ("You think I imagine everything."); and the student, in defense, offers a weak, equivocal denial ("I didn't say that.").

Earlier in this chapter, I observed that when younger staff treated patients, there seemed to be more "give and take" or conversational exchanges, providing more opportunities for the patient to introduce moral and sexual connotations. This examination illustrates one common way these exchanges may be precipitated; the staff member asks the patient's permission to perform the different parts of the examination, thereby providing a conversational slot or opportunity for the patient to refuse and voice her objections. Typically, more experienced doctors seem to exercise more control over the interaction by not asking the patient's permission. In this case, such a
"give and take" sequence begins with the student asking permission to examine the patient's chest with a stethoscope and concludes with her repeating her refusal to allow them to do the pelvic examination. As in the interview questions, he phrases his request in a manner that invites sexual implications, which the patient expresses in her laughter ("Can I check your chest?"). Like the interview, she is quick to grasp and express the double entendre significance of his questions, to the student's annoyance and chagrin. In reply, he angrily sanctions her mirth by gruffly asking if she wants the "other doctor." However, this provides an opening where she can again express her view that they are not categorizable as "doctors" (despite their "face-saving" reference to Bartlett as the "other doctor") and to repeat her refusal. Another such conversational exchange occurs in this case as the result of the student's paying attention to her protesting remark ("I don't see how you can examine people."). The student "takes the bait" and asks "Why?", which provides a slot to protest the sexual connotations of the breast examination ("I'd be very embarrassed."). Ordinarily, when such protests occur and more experienced doctors are in attendance, they (the senior doctors) merely ignore it, thereby not providing the patient an opportunity to offer further "objectionable" remarks.

Prior to his arrival in the cubicle, one of the students tells Bartlett that the patient has been "acting smart" during the interview and has been uncooperative in giving
information. So, when he initiates interaction with the patient, he immediately "puts her on notice" as to who is to control the interaction ("Just answer my questions."). In her study of gynecological examinations, Emerson describes another technique whereby staff may try to limit the patient's conversational input in order, in this case, to prevent her from introducing sexual overtones.

From conversations with doctors, the writer was able to form a picture of how the sexual connotations of examining patients were managed by the medical profession. Within a predominantly technical view of the female patient's physique, many doctors retain an awareness of the patient as a potential sex object. If a gynecologist sees a woman whose vagina has been stretched by bearing numerous children, for instance, he may think to himself or comment playfully to other doctors: "Maybe we should repair this so she can have some fun." Doctors find that it is awkward to talk about sexual matters with some women; with these women they try to conclude the scene as quickly as possible, perhaps, even cutting short the taking of a medical history. A doctor may consciously turn the edge of embarrassment which most women feel in connection with a pelvic examination to serve his own convenience, as one doctor reported: "If I have a very talkative patient, I have the nurse put her up for a p.e. first, before I talk to her. Then while she's on the table I ask her questions and you find the women aren't quite so loquacious in that situation."

Besides describing how the interview and examination are through and through sexual events for all participants, requiring commensurate management techniques, here Emerson points out how a medical staff may try to reduce directly (not merely to instruct and coerce her verbally) the patient's ability to hold conversational exchanges and ask questions, rendering her a more passive, controllable, and perhaps organizationally "ideal" participant.
Despite his effort to remind her of the patient's proper conversational role ("Just answer my questions.") , she, nevertheless, while he begins the pelvic examination tries to "get the floor" to introduce her complaint by a device similar to the child's technique to compensate for his assymetrical conversational rights. ¹² Like a patient, a child's utterances and questions may be ignored by adults, particularly when they are engaged in some project or other conversation.

Patients, like children, use an interactional device, "You know what?", as well as greetings or summons, to initiate conversations, and thereby introduce complaints or sexual overtones. In this case, the patient tries to use an exclamation ("Oh!") , like the child uses a greeting ("Hi!" or "Hello!") to get the attention of the doctor. However, she does not wait to see if the inquiry, "What?" is forthcoming, but instead immediately adds, "But I can't tell you, because you didn't ask." Evidently, she wants to ensure that the doctor will indeed ask "What?" by adding this teasing refusal to say anything unless explicitly requested to do so. This remark is an indirect reference to his earlier command, "Just answer my questions." used, ironically, to try to further arouse his curiosity and provoke an inquiry. The efficacy of this device is demonstrated by the fact that the "What?" is forthcoming, enabling her to introduce her complaint about "itchiness" "down there" and about the examination itself. ("It's been really itchy and sore down there. I can't stand this!") In other words, the patient has had her remarks and questions
ignored throughout the preceding interaction and has been repeatedly told that only the "doctor" is to ask questions. Now the pelvic examination is imminent and she wants to be sure that her implicit request to the doctor to be careful in the examination, since she's "itchy" and "sore," will be heard. Thus, a patient, like a child, may have to overcome restricted rights to speak and be heard, i.e., to initiate a conversation on a particular topic; consequently, she may utilize the same interactional devices to "get the floor."

Typically, Bartlett, unlike the "technically oriented" residents, tries to refrain from delivering lectures or pep-talks in front of the patient. When he does do so, he uses technical jargon which presumably reduces the chances of the patient learning the details of her problems, becoming alarmed and demanding to be included in the discussion. Nevertheless, sometimes the patient will discern that her "troubles" are being discussed and demand to be informed of her own condition; i.e., insist on being treated as a relevant "hearer" and conversationalist. This occurs in this case when the patient says, "What are you saying?" The doctor's response in this case illustrates a commonly used "exclusion device" to conceal or reduce the amount of information available to the patient, as well as exclude her as a relevant participant in the teaching session; deny that their talk is relevant to her concerns for her health by claiming it is only meaningful to those present with technical expertise ("We're talking doctor talk.").
Although they have been discussing the symptoms of her infection, he then further endeavors to evade her question by answering its presumed intent: a concern with serious illness or "abnormal" physical condition ("It's nothing bad. You're normal."). Thus, perhaps the patient will be "satisfied" with this vague, general assurance and not become alarmed, or interrupt their discussion with further questions. On other occasions, Bartlett would use the "exclusion device" of anticipating the patient's inquiry by politely asking her permission beforehand if they can discuss her case in "technical terms," as if she had conversational rights as an equal participant.

(While a student performs a pelvic examination.)

Dr. B.: "If he hurts, you kick and holler." (He begins to describe her pelvis in technical terms and interrupts his teaching to ask the patient.) "Okay if I tell him in technical terms?"

Patient: "Yes." (He continues to describe it to the student.)

Presumably, such a show of propriety reflects his concern for "the patient as person," but also it serves to inform the patient that while she is in a position to overhear, she is not to be a relevant party to their discussion, and therefore should not interrupt or "butt in." In other words, he is trying to prevent what occurred in the above case, where the patient interrupted and had to be reassured.

This case also illustrates how a patient may treat the termination of the pelvic examination as a negotiable matter
when only students are in attendance, reflecting her view of them as peers. This patient has challenged the students' authority throughout the examination prior to the doctor's arrival and does so again after he leaves temporarily by presumptuously announcing, "I can go now." She seems to be challenging their prerogative to terminate the examination, treating her own judgment as to the termination point as equivalent to theirs. In countering her challenge, the student does not assert his own authority, but implies that Bartlett may not view the examination as terminated ("No, the doctor might want to see you."). This seems strategic on his part because throughout the examination she has treated them as peers playing at being doctors, whereas Bartlett seemed to be able to make her "behave" more as a "respectful, cooperative" patient.

Normally, Bartlett does not announce or warn the patient that the students will be taking turns examining her. Generally, he does the examination then while she is propped up on the stirrups, has one or more of the students do a "practice examination" on her while he tries to engage her in conversation. He only provides a warrant or entitlement for their repeat examinations if the patient protests, as in this case, which is usually after the student is already inside of her vagina and she is in no position to refuse, just protest. This case illustrates a commonly used management method whereby the doctor tries to routinize the repeat examination and, at the
same time, imply an equality of competence between he and the students ("Does he have to do this, too? Yes, we check each other out."). Presumably, this method serves to reduce the visibility that this is a teaching session by invoking the service model, whereby they are merely trying to competently service her problems. Finally, not announcing the repeat examination or asking the patient's permission apparently serves as an attempt to prevent the patient from having an opportunity to refuse or protest, which would also allow her to introduce sexual or moral overtones into the interaction.

Like Sands' patient, who desired a paternity test, this patient, too, manages her response to his inquiry as to why she stopped taking iron pills, apparently to avoid a reprimand ("Why did you quit? I just did."). Bartlett, however, presses the matter, presumably because he wants her to see it as an important, accountable part of the prenatal regimen. Finally, she gives her motive for not taking them; "I didn't want to take them anymore." This response suggests why she managed her initial answer, since it does not provide legitimate grounds for her "transgression" and reflects a "casual attitude" toward the drug regimen as a matter of her personal likes and dislikes. In conclusion, it may be generally inferred that in the staff's attempts to collect information, medical or "personal," patients frequently manage their responses (although they may be treated by staff as recordable) because they assume that staff are concerned
to persuade and coerce them to follow prenatal regimens and will treat their responses as sanctionable. On their part, staff, while recording managed responses, often "probe" them, as Bartlett did in this case, apparently from a concern to make the patient account for any "transgression" and, thereby, have her see the importance of the regimens.

**Talk as a Management Practice**

I found in my observations that engaging the patient in small talk was a commonly used, though "risky" management practice to "distract" or prevent the patient from attending to the sexual and painful implications and aspects of the pelvic examination. One medical student described this technique to me as follows:

> Medicine is the art of deception. Doctors spend half their time practicing (medicine) and the other half covering their tracks. We talk to the patient to make our job easier. It keeps their attention away from the examination.

When students and residents do small talk for this purpose, typically they deal with topics which are warranted by the patient's "condition," her pregnancy, and status as a "clinic patient." On the other hand, older, more experienced doctors tended to deal with topics not related to the patient's pregnancy or "personal" problems. Apparently, they felt that such topics were too "risky" when dealing with unwed mothers, particularly because details of her "stigmatized" state may emerge which may result in the patient becoming more embarrassed and tense during the examination. One experienced obstetrical
consultant related to me the importance of this circumspection in selection of topic when trying to get "clinic" patients to engage in small talk.

We talk about anything other than the problems which brought them here to distract and relax them while we probe. Each doctor talks about different topics otherwise.

Bartlett's interaction with a patient during a pelvic examination provides an example of this circumspect selection of topics by the more experienced doctors.

(The patient talks about her new car.)

Dr. B.: "What does your father drive? Look at the red dot on the ceiling." (Before she can answer, he pulls down the top of her gown and begins examining her breasts. The patient then sighs several times.) "What kind of stone is on your finger?"

Patient: "Garnet."

Dr. B.: "That's my father's name. Your parents give it to you?"

Patient: "Yes."

Dr. B.: "They spoil you." (Replaces the gown over her breasts.)

At the beginning of the breast examination, Bartlett tries to start a conversation on a topic introduced by the patient, which is unrelated to her pregnancy or unwed status; automobiles. However, the patient appears preoccupied by the breast examination and begins to sigh, apparently from embarrassment. So, he tries again to establish a "state of talk" by using as a topic an object in the scene, her ring. Again, there appears little likelihood this would result in
her "condition" or moral status arising as a topic in the ensuing conversation. Besides the circumspect selection of topic, another feature of the small talk conducted by the more experienced doctors is that they utilize topics which emerge from the on-going interaction and immediate setting; e.g., talk is initiated on topics which the patient, herself, introduces (automobiles) or from physical objects they can both observe in the setting, particularly those which the patient brought with her (the ring). In fact, these are some of the same methods whereby strangers at a cocktail party, for example, typically select as topics to initiate and sustain small talk from the interaction and setting of the encounter itself.

In this regard, Roy Turner has found that one of the formal routine features of everyday encounters is the methodical way in which members enter into a state of talk, i.e., ways of attending to parts of the interaction as a basis for further interaction. For example, if members do not know each other routinely, they have to get a "ticket" to enter into or begin a conversation. One frequently used method to get this entitlement is to build the interaction on something one of the interactants brought with him. The staff in the waiting room also employed this method in initiating conversation with a clinic patient who drops in for a visit after she has delivered her baby. When the former patient comes into the area, the head nurse or social worker typically will speak first, saying, "Oh, you brought your baby!" or "What a nice baby!" Typically,
a discussion of the baby ensues, thereby establishing a "state of talk" with the patient after her long absence from the clinic. The principal point I wish to make is that a topic introduced in prior interaction or some object in the setting usually "emerges" which permits the more experienced doctors and the waiting room staff to membership the patient in some way alternative to "clinic patient." They can be seen to invoke this category in alternative to membershipship her as "patient"—where one consequence of the latter might be that it would be appropriate to introduce or suggest "problems" which brought the patient to the clinic.

On the other hand, the less experienced students and residents simply use as a basis for making conversation the warrantable fact that the woman has come to them as a "clinic patient." Therefore, they draw on the social worker's interview sheet in the patient's medical file listing her moral, emotional, and economic "problems" for warrantable "facts" concerning her "clinic" status as topics for "small talk" about which the patient presumably is knowledgeable and able to talk; i. e., the "facts" in the file are assumed to provide topics which would embrace the clinic patient as clinic patient and some for which the category member would have a value. As a result, typically these staff members engage in non-emergent small talk where the questions they ask the patient reflect a background knowledge of her "problems" based on having read the summation of her interview with the social worker
beforehand. Consequently, where one stranger may normally try to initiate small talk with another stranger by asking, "What does your husband do for a living?", the staff member often naively transforms such an "emergent" question to "When did your husband last work?", thereby betraying his background knowledge and appearing presumptive to the patient. Occasionally, this foreknowledge is so obvious it provokes a confrontation wherein the patient asks the doctor for the source of his questions, implying "it is none of your business," rather than engage in an interchange of small talk which would develop the patient's "problem" as a topic. For example, in the following case this faux pas provoked the patient to treat the resident derisively, which, in turn, resulted in the resident attempting to "put the patient in her place."

(The resident begins the pelvic examination.)

Resident: "You're in psychiatry?"

Patient: "How do you know?"

Resident: "It's on your chart."

Patient: "Ha! Ha!"

Resident: (irritated) "What did you do--go and join group therapy? I'm glad you finally made your mind up about that!"

Patient: "My boy friend goes, too, do you know?"

Resident: (accusingly) "You've got trichomonous, dear. If it's trichomonous, we'll be able to clear it up early." (He leaves the cubicle to examine the smear under a microscope.)

When the resident sanctions her for deriding him, she teasingly asks if he knows about her boy friend's therapy. However, he
ignores this and counters by treating her having a vaginal infection as if it were her moral responsibility. Thus, rather than successfully engaging the patient in small talk, his clumsy attempt at generating talk produces a "confrontation" wherein the patient disputed his right to know about her affairs in the first place. In other words, instead of getting the patient to talk about herself—a frequently used approach—she treated him as one not privileged to be familiar with her affairs. I take it that he received this reaction not only because he appeared presumptive by initiating talk with her, a stranger, as if he had background knowledge of her affairs, but he did so on a topic which would be "risky" in most encounters between strangers; her mental health ("You're in psychiatry?").

I would now like to examine another case which not only illustrates the "risky" and non-emergent character of the less experienced staffs' attempts to make "small talk," but shows they often use these exchanges as an opportunity to do some "teaching."

Resident: (as he begins the pelvic examination) "How long have you been married?"

Patient: "I don't know."

Resident: "Oh, come on. Everybody can remember that."

Patient: "Six months, I guess. Ow!"

Resident: "Relax. When did your husband last work?"

Patient: (in a loud, strained voice) "In June. Yeow!"

Resident: "Relax, relax. Two welfare checks . . . can you get along all right on that, then?"
Patient: (hushed tone) "Yes. Ow!"
Resident: "Did you work before marriage?"
Patient: (quiet voice) "No. I was sick."
Resident: "What?"
Patient: "I had Mono."
Resident: (after completing the examination)
"Everything's all right. Clean inside and out. Okay from our point of view. Mono is hard to get over, but nothing to worry about. Come back in three months to check and we'll see you sooner if there's hemorrhaging. But you're not pregnant."

Patient: "I've been trying."

Despite the fact he already knows her husband has been out of work and she has not worked, he asks her about these "facts" in a series of didactic questions apparently to bring them to her attention so she will draw the conclusion for herself that as a welfare recipient she should not be, or try to get, pregnant. However, instead of distracting the patient to relax her, he apparently keeps her tense since she complains a great deal. I take it that this is due to the fact that while she is talking during the examination, it is on a topic related to her "clinic" status, and this proves embarrassing. Thus, while these staff members may not provoke a confrontation in every case, where a "state of talk" is established, it often fails to distract the patient because of their use of "risky," non-emergent topics and attempts to "instruct" her.

To conclude my discussion of small talk, I would like to examine another case illustrating quite explicitly these staff members' use of instruction talk as a mode of "small
"small talk." In the process, he engages in some instruction which explicitly raises details of her moral character and circumstances.

Student: (as he begins the breast examination) "Have you decided about the baby?"

Patient: "No."

Student: "It gets harder as you go on. You should see someone who is reasonable. It's hard to when you're down yourself. Bit of a worrier?"

Patient: "No."

Student: "Oh, come off it! You look like the concerned type. You live at the Home (for unwed mothers-to-be)?"

Patient: "Yes."

Student: "Home girls are clean and nice. Not like other girls who come in here from you don't know where and have bugs and all kinds of diseases. When I start to feel sorry for myself I go talk to them. We don't like them."

Patient: "I like it there."

Student: (after feeling her abdomen) "You're right--about five months. I'll get the nurse to set you up." (He leaves to get the nurse and remains in the cubicle while she is "put up").

The student has read the social worker's sheet on this patient and draws his topics from it. He already knows from it that she is undecided about giving the baby up for adoption, as well as the social worker's judgment that this is due to the patient's "emotional state." Also, he knows from the file
that she is staying at the Home. He tries to impress on her the need for an early decision about the disposition of the baby on the grounds that it is for her own good, since "It gets harder as you go on." Actually, the social worker is concerned to have an early decision because it is easier to get a baby adopted if it is newborn. Also, both she and the staff regard parenthood as a rationally planned event, even before conception. Thus, if she remains indecisive, presumably she may not make the prescribed plans for its economic and social "well being." He then makes a presumptive "diagnosis" of her "indecision" as being symptomatic of her emotional state. Apparently, he asserts this to persuade her to see an adoption counselor. He presses this psychological characterization by trying to get her to admit that she in fact has this personality trait ("Bit of a worrier?"). When she denies this he sanctions her, implying that she is being evasive or managing her response ("Oh, come off it!"). Next, he provides a contrast conception between the girls from the Home and "other girls" whereby Home girls are to be morally (and medically) redeemed from their unwed status via an invidious comparison with "other girls" who are "worse off." This illustrates a frequently used management technique whereby a general, abstract contrast conception is provided which allows the hearer to membership herself in the morally redeeming category ("Home girls"). Then he tries to teach her how to use this categorization "therapeutically" by finding an
incumbent of the "morally inferior" category and discussing with her her problems. Again, he does not explicitly flatter her or direct her to use this procedure. Instead, he relies on her hearing the pronoun "I" and "myself" as referring to herself when he tells her, "When I start to feel sorry for myself I go talk to them." He concludes this attempt at therapy through moral redemption by allowing her to hear, or infer, that by comparison to "them" (the "other girls") she has the organization's ("We. . .") approval. Generally, his attempt at "therapy" seems based on his initial assumption that her "indecision" is, as the social worker describes, symptomatic of unobservable psychological processes. Thus, instead of engaging in small talk which deals with topics that "emerge" from the interaction and deals with topics unrelated to the patient and moral status, the less experienced staff members rely on the social worker's sheet for topics and try to "instruct" the patient with regard to them. In this case, the student apparently tries to "follow up" the social worker's efforts to persuade the patient to make an early decision on the disposition of the baby.

As in the waiting room, patients who voice an intention to have an unmedicated ex-hospital delivery in the cubicle area often receive from staff members strong moral arguments. In dealing with these patients, the residents and students seem to favor the management technique used in the waiting room; the shock tactic of relating anecdotes wherein such "natural
childbirth" results in horrible consequences to the welfare of the baby and mother. Also, the following case illustrates the fact that they treat even inquiries from patients about ex-hospital delivery methods as warranting the same strong arguments as does a declaration of intent to have an ex-hospital delivery. In these cases, they seem intent on showing the patient that it is not a viable alternative to an in-hospital delivery. Apparently, they see giving her information on "home delivery" as serving only to "encourage" it, rather than providing the patient the basis for making an informed evaluation of various styles of childbirth.

Patient: "How do you give birth at home?"

Resident: "I'd advise against that."

Patient: "But I know two girls who have done it."

Resident: "There's no point in doing a dumb thing since the difference between a live birth and one that isn't is big. What if the baby is born with a cord around its neck? Or is not breathing? Or if you start to bleed? What can you do? You don't have the equipment or oxygen."

Patient: "But nothing should go wrong if it's normal. Besides I can always do something at home if something goes wrong. Anyway, I'll decide about that when the time comes. Can I have a natural childbirth in the hospital? No sedatives, etc.?"

Resident: "Yes. We carry lots of patients who have so-called natural childbirth. In the hospital you can have the baby anyway you want."

Patient: "I'm going to do it that way if I do it" (in the hospital--J.E.F.).

The resident does not answer the patient's initial question about birth at home, but, instead, simply condemns it as not
a matter for consideration. In her reply she implies he should not condemn it out of hand in light of the fact that women can do it successfully. Apparently irritated at her arguing the point, he still does not answer her initial question and continues to simply condemn it as an alternative. He then tries to impress on her the value of life, and that an ex-hospital delivery is "dumb" in the sense of being "irresponsible" in terms of this value. Next, he tries to dissuade her by utilizing his medical knowledge of the possible "troubles" that can occur in delivery. He implies that for her case these "troubles" are a strong possibility if she follows through with her presumed intent to have an ex-hospital delivery. As with the arguments used in the waiting area, he, too, implies that only the hospital staff have the expertise and resources to prevent these common "troubles" from becoming threats to life. Again, this illustrates how clinic staff do not treat the style of childbirth as a matter for the patient's choice, and, simply tell her the actual probabilities of these "troubles" occurring in her case and the actual relative safety of an in-hospital delivery in her case. In other words, he cannot just advise that she go out and take her chances, while admitting that the hospital does not always succeed in preventing these troubles from becoming fatal. Instead, he tries to shock her with a didactic recitation of the assertedly common "troubles" of delivery in order to show her that childbirth is generally problematic, and especially
if undertaken outside the hospital. Presumably, the doctor invokes this view of childbirth as a matter of life and death to "scare" her into cooperating with his recommendation for an in-hospital delivery. He does so, apparently, relying on the assumption that every woman shares with the medical staff the high value placed on life. Nevertheless, the patient seems to try to debate him point for point. First, she asserts the empirical probabilities of an ex-hospital delivery being successful (while the doctor does not). By focusing on the actual probabilities involved, she tries to show him that this option is a viable one ("But nothing should go wrong if it's normal.") i.e., a childbirth is usually not a life and death matter. Secondly, she disputes his claim that the hospital has a monopoly on competence in dealing successfully with these common "troubles" ("... I can always do something ... .") Thirdly, she implies that she sees him as trying to foreclose this as an option for her consideration. Accordingly, she asserts that despite his arguments, she still sees it as a matter for her decision, and implies that she wants to keep her "options open." ("Anyway I'll decide about that when the time comes.") Finally, her question about the possibilities of non-medicated childbirth in-hospital suggests that her initial question about ex-hospital delivery was probably just that, an inquiry, and not a statement of intent to have an ex-hospital delivery. In other words, apparently the patient takes this examination as an occasion to explore
with the doctor different styles of delivery, rather than to simply get his advice on how to pursue one style of delivery. On the other hand, the resident's reaction to her initial question treats the topic "style of delivery" as not a matter for inquiry. Instead, he seems to regard the question on how to do a style of delivery morally, as indicating the intent or commitment to use that method, and speaks to the correctness of this presumed commitment. Thus, as with staff's treatment of questions from a patient on what they are doing to her in the examination or whether anything negative has been diagnosed, he speaks to the presumed intent, not the literal, substantive content, of her question. Generally, staff seemed more concerned with "cooling out" or "reassuring" the patient who asks questions, as well as trying to exercise moral control over her, than with simply informing or teaching her the technical "facts" which such questions seem literally to require. Similarly, in answering her question on the availability of non-medicated childbirth in the hospital, he does not simply answer the question but adds a "sales pitch" to try to persuade her to use the hospital as the site for her delivery ("Yes. We carry lots of patients who have so-called natural childbirth. In the hospital you can have the baby any way you want.") However, the patient implies that it is still her decision to make. She will keep her options open and is not completely swayed by this selling of the hospital as a site for "natural," or non-medicated, childbirth ("I'm
going to do it that way if I do it in the hospital." Throughout this sequence, her general stance of "independence" or "open-mindedness" serves to highlight the management techniques employed to morally control and limit the styles of delivery the patient will consider.

In contrast to the staff's frequent use of "shock" techniques, the teaching consultant, Bartlett, and the Chief Resident, Carls, primarily used presumptive guidance and "sales promotions" when trying to teach the patient the necessity of an in-hospital delivery. Again, this difference in management approach probably reflects their different approach to "handling" patients generally as "persons" rather than as "technical objects." For example, here is a case where the unwed patient's social work interview sheet mentioned that she "plans to have baby at home with midwife and get Welfare assistance for child support." At the conclusion of the initial examination, Bartlett tries to persuade her to deliver in the hospital instead.

Dr. B.: "There aren't any satisfactory midwives in this province, but the Hospital is well attuned to natural childbirth. This is one of the biggest centers of natural childbirth. They won't force anesthesia on you."

Patient: "I'm not afraid of it being forced on me. It's just that the hospital is such a negative place. People rushing in and out, poking about, and uttering irrelevancies."

Dr. B.: "I know what you mean. You can balance that off against getting good care. First, you have to work some to try to establish rapport with one of the interns or nurses--both have to work at it. Second, come to the hospital as late as
possible. Third, request natural childbirth as soon as you get there. You're going out to an island where there is no hospital so see a doctor every week for the last six weeks and keep tabs on your weight. Come back in two weeks, if you can. Otherwise, good luck. When your contractions come down to five minutes apart, or you break your waters, come in. (B. says to the students after she has left: They're human beings. You can't try to talk them out of it. Instead, agree with them in order to gain rapport. After all, she was right anyway.)"
availability of resources to carry it out in her particular case, rather than seeming to reject it on principle for any case, which may appear more "arbitrary." In fact, he presents this technique to the students as the prescribed method to deal with such patients ("... agree with them in order to gain rapport."). However, as I have described, neither they nor the residents routinely employ such an approach, favoring, instead, to more directly try to "talk her out of it." After all, their model of the patient is that of a "baby" who requires authoritative guidance. Thus, here again Bartlett tries to anticipate the "technical approach" which the students will encounter when working with clinic staff, and tries to persuade them not to follow it by providing both a counter recipe ("agree to get rapport") and an ideal model of the patient which justifies its adoption ("They're human beings.").

Returning to his initial remarks to the patient, I contend he not only provides a show of agreement, but tries to persuade the patient to treat the hospital as an adequate substitute for midwife care by presumptively asserting an equivalence class between the two methods of delivery, based on the criteria that the essential service sought from the midwife can also be obtained from the hospital; an unmedicated or "natural" childbirth. Then, he proceeds to "sell" the hospital as a site for this presumably sought-for "natural childbirth." ("This is one of the biggest centers of natural childbirth. They won't force anesthesia on you."). However,
in her reply the patient shows that this equivalence is indeed presumptively asserted by implying that his criteria of similarity is not important to her. She implies that she did not turn from the hospital to a midwife because anesthesia was "forced on her" in the past as Bartlett assumes. ("I'm not afraid of it being forced on me. It's just that the hospital is such a negative place.") In other words, she claims that she sought the services of a midwife because of a point of dissimilarity between that and the hospital which he glossed over in his attempt to "sell" the hospital as being equivalent to a "satisfactory" midwife; the treatment she would receive as a patient in any hospital, regardless of whether they are "centers of natural childbirth" or any other style of delivery. In response, Bartlett again tries to provide a show of agreement ("I know what you mean.") so as to preface or "set up" his counter remarks as appearing to be based on his concern for her particular circumstances and "well being," rather than disagreement with her criticisms of hospital care. In other words, his counter remark, "You can balance that off against getting good care," does not suggest he argues with her complaints. Instead, he implies that an important point of dissimilarity between the midwife and the hospital, "good care," overrides these "disadvantages." Apparently, he is still taking care to imply, too, that he may agree with the use of a midwife, at least "in principle." In any event, his effort to make an invidious comparison, albeit mild, shows he has heard from the patient's
remarks that "natural childbirth" is in fact not the essential service she is seeking from a midwife, because he shifts the grounds on which to persuade the patient: "good care." However, here again he is being presumptive in assuming that the essential purpose of using a midwife is receiving "good care." Also, he is drawing on the same resource as the clinic and waiting room staff who use more blatantly moral arguments: the assumption that any woman shares with the medical staff a strong concern for the value of the survival and "well-being" of the baby and mother.

Having made a "sales pitch" for the hospital as a place where she would receive "good care," he proceeds to presumptively advise her on how to receive medically supervised prenatal care ("You're going out to an island where there is no hospital, so see a doctor every week for the last six weeks and keep tabs on your weight."); as well as on how to receive "natural childbirth" in the hospital (presuming she is going to use one), and on how to minimize the aversive treatment in the hospital about which she complains. In the process, he implies that the poor treatment she has received may, to some extent, be her own fault, too ("First, you have to work some to try to establish rapport with one of the interns or nurses--both have to work at it."). Thus, he seems to be trying to subtly defend hospital treatment by presumptively locating the cause of her "negative" treatment in her own behavior; i.e., she may have invited or "asked for it." On the other hand, his advice to "come to the hospital as late as possible" implies that he agrees with her that
hospital treatment is inherently "poor." He implies that, therefore, all she can really do is try to reduce the effects of this treatment by reducing the amount of time spent there, presuming she is going. This presumptiveness seems particularly evident when he advises her on when to go to the hospital after the onset of labor.

In conclusion, evidently Bartlett's (and Carl's) ideological ideals regarding the patient as a "person" result in variation from the staff's everyday, work-located practice of using "shocking" anecdotes and lists of possible "troubles" in presenting moral arguments against ex-hospital delivery. While like the rest of the staff, he appeals to "good care" and tries to "sell" the hospital as a site for "natural childbirth," he does so after first trying to establish a show of agreement with the patient's choice of ex-hospital delivery style. Also, he ties hospitalization to "natural childbirth" as a way of establishing an equivalence class with ex-hospital styles of delivery, rather than merely praise, as does the rest of the staff, the extent to which the hospital provides for a "natural childbirth." Finally, he employs "presumptiveness" more than do the rest of the staff in order to try to subtly "guide" or "push" the patient toward choosing an in-hospital delivery, rather than simply and directly trying to "talk her out of it" by moral arguments.

In the clinic, Bartlett (less so the other staff members) usually delivered a general didactic talk to the
patient on her initial visit dealing with the medical perspective on pregnancy and the prenatal regimen. For example, in the following case, the patient has been examined and returns to the curtained area of the cubicle. While she is gone, Bartlett lectures the students on the importance of giving the patient advice. When she returns, he proceeds to give her a short lecture on the prenatal regimen she should follow.

Dr. B.: "A patient comes to us for help; and you can't just fill out forms and let them go. You have to tell them about their health and give 'em some advice. (The patient returns and he asks her a "leading" question.) Do you know anything about pregnancy and childbirth?"

Patient: "I learned something from my cousin."

Dr. B.: "Pregnancy is normal and natural and should be no problem if she follows rules and gets some exercise. (He seems to address this to both the students and the patient.) (He asks the patient another "leading" question.) Do you like salt?"

Patient: "Yes."

Dr. B.: "Report immediately any severe headaches or pains. Avoid salt! It is very poisonous to the baby and the mother later on. Do you like liver?"

Patient: "No."

Dr. B.: "It's the best thing for mother and baby. Eat lots of meat. At least twice a day. Cut out starches, anything with salt in it; pickles, peanuts. Do you like German sausage?"

Patient: "No."

Dr. B.: "You're over-weight. The sort of girl you are, you'll put on weight if she doesn't watch it. Your next visit will be to check the growth of the baby and your health. They won't include an internal exam. You won't see the same doctor each time; but they'll do the same thing."

His initial question concerning her knowledge about childbirth,
I assume, is not intended literally to be a serious polling of her present state of knowledge before giving her advice. My interpretation is borne out by the fact that he seems to ignore her vague reply and does not probe it to ascertain how much she learned from her cousins. He could have simply began giving a lecture to her as soon as she returned; but this appears to be a more circumspect and persuasive technique utilizing a prefatory conversational device which is used in everyday discourse by salesmen and lecturers to get the audience's attention and provide a warrant (in their assumed deficiency in knowledge about a topic) for the subsequent lecture.

While speaking directly to the patient after she returns, Bartlett also seems to intend his talk to her to be heard by the students as a lecture to them. He makes this explicit in his admonition about the patient's weight, where he refers to her in both the second person and third person pronoun ("The sort of girl you are, you'll put on weight if she doesn't watch it."). He uses this device of switching the person of the pronouns apparently in order to try to use the patient's case as a teaching object without seeming to improprietously ignore the patient, who nevertheless came for "help." Sands and the other teaching residents usually simply ignored the patient and spoke of her in the third person in her presence, treating her explicitly as a teaching object.

Bartlett seems to convey some implied threat of some
vague "problems" if the patient is not prepared to be obedient and conform to whatever rules he specifies ("... pregnancy should be no problem if she follows rules and gets some exercise."). He prefaces his specific advice about exercise and diet with this general admonition apparently so that she will see his advice and rules as intended for "her own good" and, therefore, to be obeyed. In describing dietary prohibitions, he dramatically states the effects of eating salt as being "very poisonous to the baby and to the mother." Later he refers to liver as the "best thing for mother and baby." With both of these foods, he makes an explicit reference, therefore, to the welfare of the mother and baby as the warrant for her observing his advice. As in the attempts by waiting room staff to manage patients who intend to have a non-medical childbirth or avoid medical prenatal care, he makes explicit and implicit threats of "trouble" for the baby if the patient does not follow rules and does not "cut out" salt from her diet. Like those staff members, he does not treat the following of the prenatal regimen as a matter of choice for the patient; he treats it as self-evident that any sane, reasonable woman values her baby's health and, therefore, heeds such threats. Apparently, he, too, feels responsible to society for the welfare of the unborn child and the health of the mother and attempts to manage her by making explicit and vague threats of dire consequence. Thus, it is assumed that the patient does not have the right to risk prenatal "complications."
Bartlett also uses the device of tying an admonition to watch her weight to the patient's particular build ("The sort of girl you are, you'll put on weight."). In other words, apparently he intends to make the routinely delivered warning of "watch your weight" more persuasive by claiming it is warranted by her particular "sort" or type of build. In concluding the interview, he mentions that she will not be given another pelvic examination. Apparently he does this on the assumption that the pelvic examination is one of the reasons that patients avoid using the clinic. Thus, he tries to encourage her return by promising that this aversive experience will not be repeated.

In the following case, Bartlett delivers a prenatal lecture to a patient who has experienced bleeding as a result of an operation in the pubic area. Here the patient has dressed and returned to the cubicle after the pelvic examination.

Dr. B.: "Keep your health good. Keep your weight down since you are a little bit of a thing. Eat proper meals: orange juice, salad, meat, raw fruit."

Patient: "I gained weight fast over Christmas."

Dr. B.: "Lots of fluids: six glasses a day, and no iron until your nausea settles. Do you do a lot of exercise?"

Patient: "no."

Dr. B.: "Do a lot of exercises to get away from the kids; and it may even be good for you; tennis, swimming, badminton, archery. If you do them, it can be better with the children you have if you spend some time away. If bleeding or cramps occur, come to the clinic; and don't believe any wives tales about bleeding."

Patient: "I don't listen to them."
Dr. B.: "If your pregnancy is normally progressing, then bleeding doesn't matter. You're having sex less often due to the bleeding?"

Patient: "no."

Dr. B.: "If you do bleed, then nature may be telling you to cut back a little. Bring in a urine sample; and we'll see you in a month."

As in the last case discussed, he ties an admonition to watch her weight to her specific physical build. Apparently, whether a patient is large or small, he can justify his instructions on the grounds of her build. The patient's remark about gaining weight over the Christmas holidays shows she has been "well-programmed" in the medical ideology and sees weight gain as a sanctionable matter to be "confessed" to the doctor. Next, he tries to "sell" her on an exercise regimen by claiming it will provide a chance to get away from her children, which he apparently assumes the typical mother seeks to do. The "real" or medical rationale he downplays with the word "even" ("be good for you"). Further, he even claims that the exercising will be good for the children she has by allowing her to be absent from them for a period of time. Thus, while de-emphasizing the medical rationale (which he apparently assumes would not be as persuasive), he emphasizes the strictly lay or non-medical benefits of the regimen which are assumed to be sought by the "normal" or typical housewife with children.

Bartlett tries to anticipate "complications" (bleeding) and "normal troubles" of pregnancy (cramps) the patient might experience. In so doing, he tries to impress on her the
importance of using a medical source for "help" and advice, rather than lay or folk medicine which he denigrates as "wives tales." In reply, the patient implies that she has been exposed to this sort of lay advice before and displays the medically prescribed approach to these sources of advice ("I don't listen to them."). He then tries to "normalize" bleeding later on in pregnancy, apparently in anticipation of the "wives tales" he assumes she will be hearing on the subject ("If your pregnancy is normally progressing, then bleeding doesn't matter.").

In the previous case discussed, Bartlett elicited information from the patient about her daily habits before giving advice about them: "Do you like salt" Patient: Yes. B.: . . . Avoid salt! It is very poisonous to the baby and the mother later on. Do you like liver? Patient: No. B.: It's the best thing for mother and baby." In this case, he also uses the same procedure: "B.: Do you do a lot of exercise? Patient: No. B.: Do a lot of exercises to get away from the kids; . . . . You're having sex less often due to the bleeding? Patient: No. B.: If you do bleed, then nature may be telling you to cut back a little." I take it that he first elicits this information from the patient in answer to these "leading questions," or points out visible features of her "condition" (e.g., her build) before giving advice to make it appear warranted in terms of her present habits and "condition." On the other hand, when they deal with patients making their first visits, most of the rest of the clinic staff simply issue
advice, admonitions, and warnings without trying to first demonstrate to the patient their warranted character in the patient's circumstances. Presumably, the patient may, in these cases, find such advice presumptive or even insulting. Sands: "See the dietitian. Eat salads, meat, orange juice. Get help by calling here." Note that in eliciting information about the patient's frequency of intercourse, he shows greater circumspection than when asking "leading questions" about her other less "intimate" habits, such as her diet or exercising routines. The main evidence for this observation can be found in the way he formulates these more "personal" "leading questions"—via what Sacks has called correction invitation devices (Cid’s).

Instead of asking a straightforward question to elicit information on her rate of intercourse to warrant his advice to "cut back a little" (e.g., "How often do you have sex when you're bleeding?") , he invites her to correct his assumption that she regulates the frequency according to her medical condition (bleeding). This device serves to get the information from the patient with less risk of her treating it as a moral question about her "normalcy" in having intercourse.

Finally, his advice on "cutting down a little" on sexual intercourse is justified by the invocation of an anthropomorphic conception of "nature" that gives "signs" of "trouble" in the form of bleeding. He seems to be exploiting a lay view of physiological events as being governed by a
mystical, unseen force to justify his advice, rather than the "medical facts" of her case or his own authority as her doctor.

In private practice, too, a similar prenatal lecture may be routinely delivered once the patient has been diagnosed as pregnant. Here a private obstetrician relates his standard procedure for persuading the patient to view her new status from the medical perspective.

(The doctor has just told the patient that she has been diagnosed as pregnant.)

Finally, Bonnie asked, "Dr. Sweeney, you're absolutely positive? I mean, it's definite?"

"It's definite, Bonnie."

"Oh, that's wonderful. I can't believe it. I can't wait to tell Syd. He won't believe it!"

"Why?" I asked.

She blushed. "Well, he will--I mean, this is the first time we tried, and it just happened."

I smiled. "Do you have any questions?"

She looked surprised and then shook her head, which is not unusual, because when I've just told a woman she's pregnant, she's so excited she can't remember her first name, let alone what her questions are. So I have a sort of spiel I usually deliver about pregnancy: I give the lady her vitamins and iron and tell her to keep her weight gain down to twenty pounds. She is not eating for two, that's an old wives' tale. And I explain what she should eat--the proteins and vegetables and things like that. I tell her she'll come back to be examined every four weeks until the seventh month, then every three weeks, then two weeks and then every week or more often if she needs it. I go through all this so when she's told at seven months to come back in three weeks, she won't suddenly exclaim: "Three weeks! What's wrong?" And I tell her not to expect to feel the baby move for four and a half to five and a half months. Otherwise she'll be convinced the baby's dead because it hasn't stirred when she's three months pregnant.

I try to anticipate what she's going to worry about. I
always say there will be certain days when she won't feel so hot, and there may be some nausea. After all, something has to give as this uterus gets bigger, and the bowel and stomach get pushed out of the way. I say her back is going to ache and her feet sometimes will be swollen; and she'll have to go to the bathroom more often, including in the middle of the night. The discomfort will get worse as the uterus gets bigger and pushes on the bladder.

I explain that in the first part of pregnancy, nature wants her to slow down, so she becomes tired. In the middle third of pregnancy, everything's fine: suddenly the nausea is gone and she's got her energy back. But toward the end, it's going to happen all over again.

I try at this point not to mention the abnormal things. All the women have heard about them anyway. If I just say, "Edema is a danger sign," they've all got swelling and excess fluid. So I don't bring it up as long as I'm watching each lady so closely. Obviously I tell her that if she has any bleeding she should let me know. And I always advise her to buy a book about pregnancy--but please not to concentrate on the section about abnormal obstetrics! I encourage her to go to some classes, whether or not she's thinking of natural childbirth, because she'll learn a lot. I also say that pregnancy is a physiological process; there's nothing pathological in being pregnant; you're not sick. But there are a lot of old wive's tales connected with pregnancy, and I tell her to call me if she has any problems. And finally I warn her: "Druggists are worthless; husbands don't know much; and mothers and mothers-in-law--forget it." The woman who comes into the hospital and has her gallbladder or appendix removed doesn't leave feeling she's an expert on these operations, but a lady has one baby and she'll be delighted to tell you all kinds of things about being pregnant, most of which are incorrect. Now, not every doctor runs a pregnancy the same way I do. I may be more liberal in some things and not as liberal in others. But once I've assumed responsibility for a lady's care, she's in my ball park and has to play by my rules.

Bonnie listened to all this, nodding, and she didn't seem as filled with anxieties as I expected. "Bonnie," I said, "you're going to go home and talk to Sydney and I know darn well you're going to come up with a bunch of questions. Write them down and bring in your list next time so you don't forget them. And remember, you can call me if you want to ask something in the meantime."16

This doctor seems to draw on his medical knowledge of "normal prenatal troubles" to anticipate her complaints and fears.
He then tries to "teach" her the medical view of these "troubles" by trying to "normalize" them as occurring to most pregnant women. Like Bartlett, he utilizes the folk view of "nature" as a governing, invisible force which makes "signs" of its "will" which the doctor acts as an authority to interpret. He uses this management device in this case to normalize anticipated "troubles," such as becoming easily tired--rather than go into a technical explanation of the medical "facts" causing these "troubles." Also, like Bartlett, he assumes the patient has been and will be exposed to folk medicine, which he pejoratively labels "old wives' tales." Thus, he tries to persuade her to ignore and disavow these practices and beliefs by encouraging her to do some "homework": reading medical texts and attending childbirth classes where the medical perspective is taught. Also, to this end he, himself, emphasizes a partial medical view wherein "There is nothing wrong with pregnancy; you're not sick," while not teaching her the abnormalities that may occur and discouraging her from studying this medical aspect of pregnancy and childbirth ("--but please not to concentrate on the section on abnormal obstetrics!"). Without mentioning it explicitly, he portrays folk medicine as viewing childbirth as involving many pathological processes. Thus, he teaches her a partial view of the medical perspective which deals with the "normal troubles" and non-pathological processes and avoids discussing "abnormal obstetrics" which may support or reinforce this folk pathological
conception of pregnancy to which he assumes the patient has already been exposed: "I try at this point not to mention the abnormalities. All the women have heard about them anyway. . . ."

The same private obstetrician's experiences bear out this interpretation of the relationship between attempts to conceal information about medical abnormalities and the doctor's assumption that the folk medical view involves a conception of the pregnant woman as subject to many pathological processes, and therefore basically "sick."

Now I believe in being perfectly honest with my patients--and all the more so as they go into the last few months of their pregnancies, by which time we have built a basis of understanding. This doesn't mean that I go into all of the technical details or abnormal possibilities which would serve no purpose except to frighten the expectant mother unnecessarily--one of the reasons I so despise ominous Old Wives Tales.17

Sweeney, in the lecture described above not only uses selected medical "facts" to persuade the patient that pregnancy is a "normal, physiological process" with just "normal troubles" to be expected; he also explicitly locates specific folk sources and castigates them as ignorant or not useful. At the same time, he implies she should use him as the sole reliable, valid source of "information" about pregnancy and childbirth. Next, he tries to teach her the medical view that pregnancy is an event to be "run" or governed by a specific doctor who has his own particular prescriptions and proscriptions which, nevertheless, patients are to regard as binding, as rules of a game are binding on the participants. In other words, he is putting
her on notice that if she wants to receive his care she must regard him as the ultimate authority on all matters related to pregnancy and childbirth and, therefore, should treat his rules about the prenatal regimen as sanctionable constraints. Thus, the doctor sets himself against not only folk sources but other doctors, as well, who may have somewhat different approaches to the prenatal regimen. Apparently, he is trying to get her to see pregnancy and childbirth as not so much an event over which she has control, but as falling in his sovereign domain; wherein his rules are the only ones sanctioned as legitimate. He concludes his "spiel" by encouraging her to use him as the sole source for answers to her questions. Apparently he has a model of the typical or "normal patient" as one who finds pregnancy and childbirth problematic, a cause for anxiety and inquiry. He anticipates that this will be her reaction and tries to persuade her to draw up a list of questions and wait until the next visit to have them answered—or, phone in the meantime, presumably, to prevent her from turning to lay or folk sources for answers or reassurances.
FOOTNOTES

1. James M. Henslin and Mae A. Biggs, "Dramaturgical
Desexualization: The Sociology of the Vaginal Examination," 
in James M. Henslin, ed. Studies in the Sociology of Sex 

2. Roy Turner, "Some Formal Properties of Therapy Talk," in 
David Sudnow, ed. Studies in Social Interaction (New York: 

3. Erving Goffman, The Presentation of Self in Everyday Life 

4. William J. Sweeney, Woman's Doctor: A Year in the Life of 
an Obstetrician-Gynecologist (New York: William Morrow and 

5. Joan Emerson, "Behavior in Public Places: Sustaining 
Definitions of Reality in Gynecological Examinations," in 
Hans Peter Dreitzel, ed. Recent Sociology No. Two: Patterns 
85.

6. Joan Emerson, "Social Functions of Humor in a Hospital 
Setting" (unpublished doctoral dissertation, University of 

7. Lewis Yablonsky, The Violent Gang (New York: Free Press, 
1962).

8. Emerson, "Social Functions of Humor in a Hospital Setting," 
p. 89.

David Sudnow, ed., Studies in Social Interaction (New York: 

10. Bruce Katz, "Conversational Resources of Two-Party 
Psychotherapy" (unpublished Master's thesis, University 

11. Emerson, "Social Functions of Humor in a Hospital 
Setting, p. 46.

12. Matthew Speier, How to Observe Face-to-Face Communication: 
A Sociological Introduction (Pacific Palisades, California: 


17. Ibid., p. 143.
CHAPTER V

LABOR AND DELIVERY: THE ORGANIZATION OF WORK ROUTINES

This chapter documents the intransigence of labor and delivery as "raw materials" for organizational programming, as well as the patient management routines developed to cope with the naturally difficult features of these processes in terms of the demand characteristics of scheduling them as work and providing a visibly competent performance while "aiding" these processes. Also, I will try to show at the beginning of this chapter how the ethnographic method adopted for use in my research is particularly useful for revealing features of work routines, including management techniques and the "problems" or "complications" they cause obstetrical patients in labor and delivery. The efficacy of this research strategy will be contrasted with a structural survey approach to theory and method which imposes the researcher's organizationally alien view of events in the hospital as resulting from extra-hospital attributes and processes of staff and patients (e.g., social class, social psychological attitudes, beliefs, etc.), and thereby often produce demonstrably spurious analysis of such organizational events as labor and delivery.

When studying childbirth, sociologists generally concentrate on finding statistical relationships between
"medical" or "physiological" events and "problems" experienced by the patient in the delivery room, and the patient's and staff's "social characteristics." Typically, this standard approach has tended to ignore how such "medical" events and "problems" are also organizational products, shaped by the medical staff's work routine. For example, one such study, entitled "Some Social Psychological Aspects of Delivery Room Difficulties" by William R. Rosengren, tries to find and explain correlations between measured "social class" of patients, their measured "adoption" of Parsons' "sick role" in pregnancy and delivery, and observed "medical difficulties" which these patients experience in the childbearing process. In his study, this researcher set up an "Indices of Difficulties," as well as collected "social psychological data" via focused interviews on patients' "perception of pregnancy as 'illness'" in terms of Parsons' "sick role."

Indices of Difficulty: Two major indices of difficult or complicated deliveries were used: length of labor time and gross complications.

Labor time was determined by means of data which were recorded for purposes of the Collaborative Study. Specifically, observers noted the time of the onset of contractions on standardized forms, and later noted the time at which the patient entered the delivery room. The lapse in time was regarded as a suitable indicator of length of labor time. . . . An operational assumption of this study was that a lengthy labor time was a greater indication of difficulty during delivery than was a shorter labor time.

Second, indices of gross difficulties and complications were drawn from the regularly maintained records at the lying-in Hospital. Notations were first made of any complications noted while the woman was in the labor room. These included such observations as unexplained bleeding,
any fetal positions or movements which seemed to interfere with the course of labor, and so on. Notations were also made of the general condition of the woman in the labor room (e.g., premature rupturing of the membranes, any abnormal heart murmurs or palpitations). Third, abnormal conditions in the delivery room itself were noted (e.g., breech position of the fetus, abnormal fetal heart beat, extreme blood pressure changes on the part of the mother, and the like). Fourth, a record was kept as to the use of forceps: low, mid or high; and mild, moderate, or heavy pressure needed. Finally, notations were made of any cord complications as to both the number of loops and their degree of tightness.

The subjects were then divided into two groups: those women who had experienced a "gross abnormality" during labor or delivery; and those who had not—regardless of the length of labor time. There were 30 women in the "abnormal" group and 64 in the "normal" category. Those women whose labor had been interrupted for purposes of sectioning were placed in the "abnormal" group, while those whose section had been anticipated from the outset were assigned to the "normal" group. ...1

By using the time spent prior to being sent to the delivery room as a "suitable indicator of length of labor time," the researcher overlooks the ethnographic observation that labor, presenting "natural" scheduling and control problems, may be prolonged or shortened by treatment routines in the delivery room itself, which in turn may be related staff's concerns for work scheduling and producing visibly competent work, rather than their's or the patient's "social psychological characteristics." In presenting his findings, this researcher provides a post hoc explanation and makes clear that the research was primarily concerned with helping doctors deal with "practical" health problems.

There was a striking relationship between length of labor time and the extent of the woman's definition of pregnancy as an "illness." Those women who expected to act "as if" they were sick during pregnancy were also those whose labor time records bore out that expectation. It seems clear
that as an anticipatory response phenomenon, this is what might be expected. These women were actually enacting a certain kind of social role during their pregnancy with which a long and arduous labor is not inconsistent.

... Of suggestive importance is the relationship between length of labor time and the incidence of gross physiologic or morphologic difficulties. The longer the labor time the more likely the appearance of a gross complication of some kind. ... If this is in fact the case, then whatever means--socialpsychologic as well as medical--by which this effect (of lengthy labor) may be reduced is of potential practical importance.

Aside from the irremediable methodological difficulties inherent in imposing the researcher's theory and categories on patients' and staff's accounts when doing focused interviews and status classifications, the primary problem with such a study lies in its implicit assumption that mainly abstract "social characteristics" and "beliefs" of patients and doctors influence the "medical" outcomes in labor and delivery. In fact, this structural survey approach detaches behavior in labor and childbirth from the organizational setting and work routines in which they naturally occur in order to impose the researcher's own theories of the relationship of certain abstract, general social classifications and belief systems and observed "medical" outcomes. An ethnographic approach, on the other hand, reveals, for example, how such assumed "difficulties" as "length of labor," "bleeding," "rupturing of the membranes," "forceps delivery," and "caesarian section" may be defined and produced to an important extent by the everyday social organization of childbirth in a hospital.

"Length of labor," for example, may be affected by the doctor's administration and regulation of the drug pitocin,
which augments and induces labor contractions. A doctor's decision to use this drug may be based on considerations of work scheduling, rather than "physiological" or "medical" criteria. In the following case in the delivery room, an obstetrician is concerned to "speed up" a patient's labor in order to meet an appointment with another doctor to consult on a caesarian section.

(Outside the delivery room) Ob. to Nurse: "Well, give her a little pitocin so the contractions will come more regularly and I won't have to wait."

(Later in the delivery room) Ob. to Patient: "These contractions are funny, go a few and disappear."

Patient: "That's the way it was this morning. It's funny."

Ob: "That's why we gave you that (pit.) to have them come regularly. (Later in the labor.) We could have waited a few weeks (to deliver)."

Patient: "I was off the pills a month so I couldn't be far off. I think I got pregnant on the first of July. I got that old feeling two weeks ago and I had these contractions earlier still. I was disconcerted when I was premature (an earlier baby) but this time I was composed."

Ob: "A healthy sign. Since the baby is premature by dates anyway, I have a consultation after one before I go home."

Patient: "That's ok. As long as you have somebody to take care of it. Dr. R. told me that you'd be too busy." (The Ob. leaves to get a resident to supervise her delivery.)

The doctor's verbalized warrant for using pitocin (suggesting it is for her own welfare) shows how medical routines dictated by demand characteristics are translated into responses to patients' "health needs." Next the doctor tries to preface or
or "set up" his exit by trying to get the patient to see that she came to the hospital in false labor. However, she counters by claiming she is not to be held accountable for bringing the doctor to the hospital on "false pretenses." Nevertheless, the doctor invokes her estimated due date of the arrival of the baby to shift grounds on which to claim it is the "prematurity" of her coming to the hospital which warrants his leaving her, rather than simply saying he has "more pressing" business elsewhere, which could call his competence into question.

A case reported by a "natural childbirth" patient also demonstrates how a doctor may try to provide an acceptable warrant for using pitocin in terms of the patient's state of labor, while actually utilizing it to fit the patient into his work schedule.

No sooner was I comfortably settled than Dr. Sedley reappeared. "How are you doing?" he asked. I had to confess that nothing much was happening. Whereupon he got out the needle again and injected another dose of that non-synthetic oxytocin preparation. Just then I noticed a large bottle that stood on the table by the wall. "You aren't planning to pump all of that into my arm?" I asked warily. His only answer was a noncommittal laugh. Almost immediately the contractions picked up with redoubled force; again there was little time in between them. (Later in the labor) Dr. Sedley was back again. I was beginning to wonder if he would go away again without giving me another shot if I said the contractions were tremendous. I brooded over this question for some time. Later on, I realized that he was probably giving me the shots on a schedule, and it wouldn't have made any difference what I said.4

Another management approach involves persuading the patient to accept pitocin by glossing its often powerful effects on labor as (euphemistically) being used to "speed
things up." Here is a case of a "natural childbirth" patient who, while trying to cope with the "normal rhythm" of her contractions, is persuaded to accept pitocin so the doctor can deal with his work load. The patient told me the doctor used pitocin when she "slowed down" in her efforts to push the baby out.

Since the doctor had other patients, he wanted to speed my contractions up. However, this caused pain and disrupted the naturally intended pace of my contractions. Plus it caused a painful lump in my arm. I wasn't aware of what they proposed when they asked me if they could "speed it up."

Finally, a private obstetrician relates how common the practice is of inducing and controlling labor via pitocin for the doctor's and the patient's convenience.

... There are those who call this (induction) meddlesome obstetrics, but I believe inductions are perfectly justifiable even for nonmedical reasons. Any doctor who tells you he only induces patients on a medical basis is lying, because he does it sometimes for his convenience and sometimes for the woman he's delivering. I had a lady who lived out on Long Island. She was terrified of Long Island Expressway on a summer night. When she got to term, we induced her rather than have her risk getting stuck in traffic.5

One of the "difficulties" claimed by Rosengren as reflecting the enactment of the "sick role" by the patient is itself a frequently used resource to regulate the "length of labor" in regard to the pacing of work in the labor and delivery rooms: "forceps delivery." Ironically, while gathering his focused interviews concerning the "sick role," Rosengren also did a non-participation observation of a delivery service, the results of which later appeared in an
article entitled "Time and Space in an Obstetrical Hospital." I say ironically because the results of his more ethnographic study itself can be used to demonstrate how the organization of work influences the frequency of forceps delivery, a fact overlooked in his structural survey study. In fact, in this later published article, Rosengren describes how forceps and anesthesia were both routinely used to deal with the work scheduling that reflects on the staff's competence and professional "status."

**Tempo: Conceptions of the "Normal" in the Hospital**

The number of deliveries taking place in a given period of time particularly relates to the tempo of the service. In the clinic service, the number of births in a twenty-four hour period may range from as few as one or two to as many as fifteen or twenty. This lack of a natural tempo seemed to be handled in a number of ways in order to impose a "functional" tempo where a "physiological" tempo did not exist. For example, when deliveries were occurring at a naturally slow pace, the residents showed much anxiety and concern over the one or two women who might have been holding up the tempo of events in labor—constantly checking and rechecking for signs of change. Similarly, in the delivery room itself, there seemed to be an attempt to impose a tempo—to adhere to a pace of scrubbing, of administering anesthesia, and so forth. There was also an emphasis upon keeping track of the length of time involved in each delivery. In terms of tempo, the unusually prolonged delivery was as up-setting to the team as was an unusually rapid delivery—even though both might be equally normal or abnormal from a medical point of view. As one resident put it, "Our (the residents') average length of delivery is about 50 minutes, and the Pros (the private doctors) is about 40 minutes." Thus, the "correct" tempo becomes a matter of status competition and a measure of professional adeptness. The use of forceps is also a means by which the tempo is maintained in the delivery room, and they are so often used that the procedure is regarded as normal.

The student externs showed particular reluctance about admitting patients to the service because of the possible
fact that the patient might be in "false labor." This would upset both the rhythm and the tempo. It may not be unrelated to the fact that such a "mistake" on the part of low-status personnel is much more crucial than a similar mistake on the part of higher-status personnel. In addition, the potential high tempo for the obstetrician is necessarily limited; he can be in attendance for just one case at a time. When the physiological tempo begins to outrun the functional tempo, the margin of safety can be partially maintained by the anesthetist who can hurry cases along or delay them, depending upon the kind and amount of anesthesia he administers. As one anesthetist joyously announced one night when the physiological tempo was very high, "I've got five going (ready for delivery but delayed) at once now."6

At City, "length of labor" often was inadvertently extended by the common use of drugs and anesthesia to "calm" and make a patient "cooperative." Patients who complained loudly about their labor pains, the treatment they were receiving, cried, did not cooperate, and appeared "too apprehensive," were given drugs and anesthesia until they "calmed down." For example, here is a case of an Italian patient who was given a narcotic to "calm" her while a resident finishes connecting a fetal monitor. It is given in this case in the early stage of labor when drugs are usually not administered because they might affect the baby and slow labor.

(Patient groans and cries.) Resident: "Ok, dear, it won't be long."

Patient: "I can't!"

Resident: "In a little while, I'll give you an injection. It's too early."

Patient: "Why?"

Resident: "We'll find out about the baby first. Then we'll take care of the pain."

Patient: "It hurts."
Resident: "You have to put up with it. This is labor. If you don't have the pain the baby won't come down."

Patient: "No more!"

Resident: "Ok. I won't touch you any more. Don't touch the instrument." (the fetal monitor)

Patient: "Ow! Yeow!"

Resident: (to nurse) "Get her a heroine." (Turns to students who have been observing) "I don't like to give pain killer too early. We'll record the fetal heart beat. If she doesn't have good contractions, we'll put a drip pan under her."

Staff tend to treat any loud "emotional" utterance or expression as a "reaction to labor pains" and therefore warranting anesthesia or drugs, whether the patient requests it or not. This observation is supported by the experience reported by a "natural childbirth" patient who found her loud summons to the staff treated by anesthetic in reply.

I was left alone in the delivery room for about 20 minutes while everyone scrubbed. At this time, without my great (labor) coach I lost control, couldn't remember what to do and began to moan and toss my arms about. Then all of a sudden the urge to push was overwhelming, and I began to yell, "Push, Push!" The nurse ran in and gave me a shot of Demerol. I hadn't really wanted it, nor had I lost control--I just wanted them to come before the baby did!

In another case at City, a patient, described by her doctor as "hysterical, very worried, and lets it all out" because she does not have the "right attitude" to delivery, becomes "emotional" in the delivery room and refuses to "cooperate" with staff in keeping her hands off the sterile sheet which covers her abdomen, and is given anesthesia.

Patient: "Ow! Ow! (grabs the sterile cloth and the nurse pulls her hands loose) I can't put my
hands down! I want something to hold on to!"

Nurse: "Just remain calm! It'll be over in five minutes."

Patient: "Oh! Dr. B., can I hold on?"

Nurse: (angry) "Don't put your hands on the green sheets!"

Patient: "I don't know! I don't know what I'll remember! Oh! Dr. B! Don't!"

Dr. B.: "It's the contractions you are having!"

Anesthetist: (when the patient continues to shout and protest he pushes the mask over her mouth) "Just breathe in and out!"

In addition to using anesthesia to obtain the patient's cooperation with medically prescribed "aesthesia" procedures, a staff may also use it to "calm" a patient who has been "uncooperative" in conforming with the "approved" position for delivery. On the other hand, the patient's behavior may reflect her view that the prescribed position and much of the routine preparation for delivery are unnecessary and interfere with her attempts to apply "natural childbirth" training to stay in "control" while in labor.

After the nurse took me to my labor room, Larry (a medical student) and Dr. Ischal came in to start my IV running, and this is where the trouble began. I was having tremendous back labor, and I had to lay on my back which made it worse. Until this time, I was in full control, but I had to tense my arms so they could find a vein. Dr. Ischal spent one and one half hours trying to start the IV and I totally lost control. He kept jabbing me with the needle of xylocaine, and then before it took effect, he'd start the IV, or try. Finally about 3 p.m., he got it to stay in, but by this time both arms were bruised all over and I was crying. I probably would have let Dr. Ischal have it but Larry managed to keep me fairly calm as Therean (her husband) wasn't allowed in. If he had been I might have been able to stay in control. At three, they examined me and I was still 5 cm. but 80% effaced. Between 3-3:30 Therean and I were alone and I was just beginning to calm
down and get in control again; he was coaching me in breathing. About 3:30 I felt two very strong contractions and I told Therean that if I wasn't afraid Dr. Ischal would examine me I'd call because I felt like I was in transition almost. Just then Dr. Ischal walked in pulling on a glove. He checked me (but not gently at all) and I was 7 cm. Dr. Patchin (her personal physician) had left word to be called between 7 and 8 cm. so he came in a few minutes later to do a paracervical block and I was in no position to object. I was so tired from all they'd done and laying on my back all but a few minutes they left us alone, that any kind of relief was welcome. Only it wasn't relief—I had to lay on my back and it took 20 minutes or so to do it all. Then all it did was numb the cervix which wasn't hurting in the first place, I still had very bad cramps and my back hurt worse. A few minutes later they brought the fetal heart monitor, and that's when I really went wild. I just sobbed; I was scared to death, and I had to turn over on my back for another 20 minutes or so. They put it in and it didn't hurt at all but my back was worse so Dr. Patchin gave me some demerol and I began to relax a bit. As soon as he gave me the shot he checked me; it was 4:30 and he said I was ready to go. They took me to the delivery room and I wasn't feeling very cooperative by then, and I was so disgusted with the effect of the medication, I wasn't in any rush to turn over on my back so they could strap me in. I finally turned over and they got me all fixed up, and during this time, Dr. Gibson (a new resident replacing Ischal) took over the floor and he just started giving me gas, which I didn't want since everything else had been no help. It's a good thing for him my hands were tied or I would have punched him out. But I guess the gas made me more passive, which was good for them because by now I was so mad at the way things were going, I was yelling at them.

Staff at City typically do not treat a patient's loud "emotional reactions" and resulting "uncooperative behavior" as possibly reflecting on the hospital's treatment routines, as this patient shows may occur. Instead, they usually locate the cause within the patient herself in terms of different "cultural expectations" which are assumed to govern how different "ethnic" types of patients should behave in labor or in terms of the patient's personality or "attitude," a
product of her past relationships. For example, one doctor claimed that Greeks and Italians "yell a lot because their mothers expect them to" or "to get back at their husband, who is usually in the hall outside within hearing distance, for not allowing them to have babies for a long time or because they want their husbands to leave them alone (sexually) and they try to stay in the hospital as long as possible. "We don't allow Greek and Italian husbands into the delivery room because it just makes the patient yell louder." Thus, staff treat "bad reactions" to labor as perhaps having a culturally determined instrumental purpose *vis-a-vis* marital relationships rather than the result of staff's treatment or the character of the labor contractions themselves. "Dramatic reactions" to labor are assumed to be "unnecessary" and physiologically "unwarranted" by the pain a patient may "actually" be experiencing. Similarly, when no "ethnic" typification can be applied to the "bad patient," her psychological characteristics are assumed to produce this "excess" of emotion and "uncooperation." For example, one doctor shows how he relies on the patient's "cooperativeness" in the doctor-patient relationship prior to delivery, as well as her "psychological background," to account for her "poor reaction" to "labor stress."

(Following a delivery the doctor discusses the patient's "performance" with me.) The background is important to understand the reaction of this patient. She's not too bright and has an inadequate personality. I can understand why her first husband beat her. Her parents adopted her first two children because she's not capable of caring for them. This husband is all right. I didn't invite or encourage him to come into the delivery room,
since although I haven't delivered any of her babies before, I could tell that her personality would not be good for delivery stress. Especially since each week she seemed to lack confidence in the delivery and her doctor (himself) and she was always voicing more doubts and asking a lot of questions.

Thus, both modes of typification accounting for "bad reactions" provide grounds to anticipate it and provide differential treatment for these "types" by excluding their husbands from attending the delivery, as well as to deflect attention from the hospital treatment routines when patients are "bad." Excluding the husband also helps to prevent such "behavior" from visibly reflecting on the doctor's competence.

Not all doctors at City treat "bad reactions" and "uncooperativeness" as warranting the exclusion of the husband and the use of anesthesia and other drugs. Dr. Bartlett and several other senior teaching obstetricians generally avoided these practices. Their approach to labor and childbirth was related to me by Dr. Bartlett after a "noisy delivery" by an "Italian" patient. An important feature of his remarks is that in accounting for a patient's reaction he seems less concerned than other doctors to deflect attention from the hospital's routines.

Different nationalities do react differently to labor. Italians and Greeks may express themselves a lot but not necessarily according to the amount of pain experienced. However, that yelling also varies with the treatment of them by nurses and doctors. In the long run, it may be better for the patients to express emotions rather than clench their teeth like the Anglo-Saxons, Indians and Chinese. Nurses and doctors see the best patient as one who doesn't cry or be apprehensive because they are Anglo-Saxon and therefore they associate crying with unhappiness and because it reflects on their competence.
There's a lot of abuse of anesthesia and drugs at City in that it may be used in the amounts and when necessary to keep the patient from being uncooperative or being apprehensive and upset or talking back to the doctor or talking disrespectfully.

I take it that Bartlett's approach reflects a familiarity with professional and academic literature which generally espouses the use of the findings of social science and techniques of psychotherapy in implementing "patient as person" ideals of the medical ideology when coaching labor. In any event, his remarks suggest that the staff's use of anesthesia and interpersonal management techniques (to be discussed) to control and quiet patients derives to some extent from their concern to give a visibly competent performance. Thus, the patient's "condition" may not be the only warrant for using anesthesia. Depending on whether a doctor implements ideals of the medical ideology in "coaching" labor and childbirth, (as does Bartlett) its use may be influenced by such mundane work concerns as scheduling and making competence visible to colleagues. The cases I have been discussing suggest how these work concerns result in the more frequent use of anesthesia and drugs which may prolong labor, a "difficulty" Rosengren assumes reflects the patient's beliefs about playing the "sick role" in labor and childbirth.

Returning to the "difficulty" of "forceps delivery," besides scheduling concerns, another organizational contingency that may result in its frequent use is whether or not teaching is one of its routine tasks in a hospital. At City, forceps
deliveries often were performed not because of "medical requirements," but because the interns on duty had to get experience at doing this operation. One general practitioner who delivered a lot of his babies at City described the routine character of this practice and pointed it out as one kind of differential treatment accorded "clinic" or "staff" patients as opposed to "private patients."

All staff patients are delivered with spinal block (a local anesthetic) and forceps on first delivery (the patient's first baby), whether it's required or not, so the interns can get practice. However, if the forceps slip, they may rip the mother further than an episiotomy. Or they may get the forceps in and not get them out and rip the mother with the rough edges. Also, if they (the forceps) slip on the baby's head it may cause brain damage.

One of the "gross difficulties," "caesarian section," used by Rosengren to indicate the effect of "social psychological" factors, is itself susceptible to use by a staff as a means to shorten labor time to schedule a "normal work day."

The following remarks by a nurse who had worked at a hospital near City suggests how the use of caesarian section may demonstrate the sanctity of work-shifts and differential treatment of "clinic" or "staff" patients. She related to me that Metropolitan Hospital has a "five o'clock policy" whereby any patient delivering after 5 p.m. is delivered by caesarian section so the doctors and nurses can have an "eight to five day." Metropolitan is located in what the nurse termed an "ethnic ghetto." "Many of the patients there are 'staff' or 'clinic', unwed, and do not speak English. Even if the husband is present, the staff explain that 'it's just the way babies
are born now." Many of the patients are scared fifteen and sixteen year-olds, unwed, who don't want to keep their babies, and want the pain over with, so they do what the staff wants. By this nurse's account, in her hospital, the doctors try to persuade a patient and her husband to accept a "c-section" by "routinizing" it as part of the latest medical approach to childbirth methods.

At City itself, patients typified as likely to have a "bad reaction to the stress of labor," i. e., "lose control" of their emotions and become "uncooperative," sometimes were given c-sections to avoid having to manage their behavior to conform to staff's image of the "good patient" (organizationally programmable) in labor and delivery. For example, one doctor just before a c-section related to me how his patient had a "difficult" first delivery and appeared "too apprehensive" for regular childbirth. This was the main reason, I was told, why a vaginal delivery was not attempted. The doctor described his management technique in this case as follows.

So I had to brainwash her with a general description of the operation and assure her how safe it is. I didn't go into detail because that would scare her since she wouldn't understand even after having experience with a previous childbirth.

When the baby was delivered, its heart beat only for a few times for the first hour and it was less than six pounds in weight. It was immediately taken to intensive care, its prognosis uncertain. Afterwards, the consulting obstetrician discussed with the doctor how one of the possible reasons for
a "poor baby" was the chance that it may have absorbed some of the general anesthesia given the mother for the c-section. He implied that even though there had been no sign of trouble prior to delivery, a vaginal birth would have reduced the risk to the baby. In reply, the doctor agreed that "it would be bad to talk the mother into an operation and deliver this way and lose the baby."

I suggest that what is of sociological interest here is not "sloppy medicine," but the fact that staff have at their disposal and utilize various medical procedures with medical rationales (pitocin, anesthesia, forceps, c-section) to control the "length of labor" and manage and avoid organizationally "troublesome patients," so as to expedite their work schedules and ensure a visibly competent performance. These staff concerns for the "shaping up of a day's work" and providing for the visible competence of that work seem to be taken for granted invariant properties of occupational routines in general. Roy Turner has termed them demand characteristics of occupational routines in his study of the influence of scheduling and visibility in organizing the routine conduct of police work. What is of significance in this ethnographic approach is not the "uncovering" of medical practices or police practices which may be disapproved of by the public (e.g., treating patients with regard to the structure of the work day or to a visibly competent performance) but the discovery of "the situational and contextual features (demand characteristics) which persons engaged in everyday routines orient to as
governing and organizing their activities.10 Such a perspective draws attention to the fact that what the public, its guardians, and social scientists regard as possible indications of "poor performance" by "public servants," or simply as "difficulties" the public encounter while obtaining service ("long labors," "forceps delivery," etc.), may in fact indicate the operation of certain organizing principles (demand characteristics) governing the service's routine.

Now I would like to discuss yet another resource staff may draw on to control "length of labor": "guiding" the patient in the delivery room to push to get the maximum effect of each labor contraction in expelling the baby. In the staff's view this entails both instruction on how to "correctly" push as well as persuading the patient to exhibit the "right attitude" or, as one staff member put it, "a relaxed and happy mental approach," so she would not become "hysterical" from labor pain and the long arduous "work" of pushing the baby out and quit pushing. While increasing these management efforts to "pressure" the woman to push when staff was concerned to shorten labor time, alternatively, they instructed her to stop pushing, although she may have had the urge to do so, when they wished to prolong the labor period and delay the delivery of the baby.

Routinely, nurses monitor the patient's progress in labor and only summon the doctor when the patient is considered advanced enough for the delivery room, usually at complete
dilatation (10 cm.) of the cervix. This frees the doctor for sleep, leisure, work at his office or in the ward, and to deliver other patients. However, when the nurses "miscalculate" in diagnosing the patient's progress, they often have to rush the patient to the delivery room and manage her to effectively "hold" the baby from being delivered until the doctor arrives, the only one permitted by organizational rules to conduct the delivery. Typically, when he finally arrives, he continues the instructions on how not to push the baby out in order to have time to "scrub up" and make an episiotomy.

Nurses evaluate the patient's progress in labor using certain assumptions about the characteristics of the typical or normal patient in labor. The patient in labor is assumed to take a certain amount of time to reach complete dilatation of the cervix according to whether she's had a baby before (called a "multigravida" or "multip"; 6-12 hours) or not "primigravida" or "primip": 6-18 hours). Also, certain noticeable "behavioral and emotional changes" are assumed to occur in this period of dilatation. Toward the end of this period (8 to 10 cm.) dilatation the patient is assumed to experience the most discomfort and appear most "agitated" and "emotional." Nurses (and doctors) rely not only on scheduled (according to whether she has had a child before) periodic pelvic examinations to detect the amount of dilatation, but also on this typical or normal change in behavioral display. Loud complaining, crying, or screaming is often treated by
nurses as the signal to do a final pelvic examination before summoning the doctor and taking the patient to the delivery room. They often account for the lack of such displays in terms of the "ethnicity" of the patient. The following remark from a nurse demonstrates this typification process and the degree to which nurses rely on "emotional displays" to evaluate labor progress and the assumed amount of pain experienced in labor, which organizationally warrants the administration of drugs for relief.

Unlike Greeks and Italians, Chinese and Indians are very stoic and hold their feelings in. Sometimes they have their babies in bed and are given too little anesthesia and analgesics.

Another "type" of patient, who in the view of staff causes "miscalculations," due to "controlled" behavioral displays, are those who have had training in "natural childbirth" techniques whereby they supposedly "breathe" and "relax" their way through labor, rather than "fighting" contractions and increasing pain. I take it that staff's recognition of labor behavior as cross-cultural matter, suggests conversely, that their organizational standards of "normal behavior" in labor reflects their own "ethnic" ("Anglo-Saxon") expectations that labor is painful (as opposed to "natural childbirth" teachings) and provokes periodic "emotional" outbursts and complaints. However, an alternative explanation for this notion of normal labor may be found in the fact that the majority of their patients were typified by staff as middle-class Anglo-Saxons. So, staff
believe they have had more exposure to this "type" of patient. Whatever the explanation for this standard, it is clear it was used to organize the monitoring and assessment of labor. This observation is supported by reports of "natural childbirth" patients' experiences in other hospitals. For example, here a husband recounts his wife's treatment by a nurse who, to some extent, apparently scheduled pelvic examinations according to patients' displays.

I had to leave at 10:45 to go to work, and as Jane had not yet been examined, the nurse arranged to do so before I left. She was very surprised to find how far advanced Jane was in the first stage; she was already 3 fingers (cm.) dilated and they clearly expected her to be making more noise and writhing around.13

These normal patient expectations can even lead to staff's denial of "obvious," observable "variations" in the progress of labor vis-a-vis the patient's "emotional behavior." In these cases, the staff may act as if the patient has not progressed as far as she actually has and, as a result, force her to conform to the hospital routine which is normally followed with labor patients. In this case, for example, a "natural childbirth" patient reports how she practiced her breathing techniques to avoid notifying the nurse of her progress, choosing to schedule her own departure to the delivery room. When the patient goes through the final part of the first stage without "screaming" and delivers the baby's head, the nurse denies that she has progressed as far as she obviously has and continues treating her as she normally would. This forces the patient to "hold" the baby from being delivered.
Then, on arrival in the delivery room the nurse treats the patient as if she's a normal labor patient who by this time has only reached full dilatation, not expulsion of the baby as this patient has; the patient is required to transfer herself from the trolley to the delivery table. The nurse's denial of progress even results in her not instructing the patient to "hold" the baby until the doctor arrived, which normally takes place when the staff recognize that the patient is being taken to the delivery room in an advanced stage of labor.

... (the patient has summoned the nurse using a buzzer)
The nurse eventually appeared and examined me. I asked her to ring my husband too. She then left to telephone the doctor and to fetch the trolley on which I was to be transported to the delivery room.

During her long absence the membranes broke. I knew then that it would not be long and pressed the bell once more. She arrived armed with the trolley which she maneuvered alongside my bed and casually ordered me to "hop on." As I was at the height of a contraction, I continued to pant. She repeated her order. As the contraction subsided, I took the opportunity to crawl from a rather damp bed onto the trolley. As she pushed me down the corridor, I had another two or three contractions, thus giving birth to the baby's head—quietly! I told the nurse what had happened, as I felt very pleased with myself. She stopped the trolley instantly and had a "peep," covered me quickly and said "Nonsense, you haven't screamed!" I was amazed at her denial so I continued the conversation no further.

We arrived at the delivery room. She pushed the trolley beside the delivery table and once more ordered me to "hop on," and went off to scrub up.

Bewildered for a few moments, I then decided that it wasn't worth an argument and somehow wriggled onto the delivery table supporting the baby's head with one hand and with the other edging my way onto the table. I do not think I could do it again, but I was so full of confidence!

The nurse by this time had returned (all scrubbed) in time
to deliver the tail end of Perdita—my gorgeous 6 lbs. 5 oz. baby girl.

Before even cutting the umbilical cord she rushed off to open the front door for the doctor, who had been ringing the door bell for the past ten minutes. All the drama was over, but he was the first to offer his congratulations. I take it that this process of typification, expectation, and denial of observed variations with resulting coercion of the patient into conforming to the normal routine also can occur in other medical specialties. For example, here is a case of a spinal injury of a returning Vietnam veteran who finds his "progress" denied vis-à-vis the Veteran Administration Hospital Staff's typification of his case as a "young (new) injury," with an expected normal rate of improvement.

Two days after I arrived at Hines (V.A. Hospital), I had my first physical therapy appointment and I was looking forward to it because of the progress I had made at Walter Reed (Hospital). That morning, I put my braces on, put my pants on and walked on my crutches down to the physical therapy room. The doctor took one look at me and said, "I thought you were a young (recent) injury." I told him that was right, that I had been wounded just a little more than three months earlier.

"Well, it's impossible for you to walk," he said.

"What do you mean?" I demanded, "You can see I'm walking, can't you?"

"Young injuries," he informed me, "never walk so soon."

So I walked back to my room, took off the leg braces, stood the crutches up in the corner and went back to physical therapy in my wheelchair. That seemed to please the doctor very much. I suppose the main thing I object to is always being categorized as a "patient." There is a nurse, a patient. Never Pete Rios (the writer). You are in a wheelchair so you are a "spinal cord injury"—not a person. You are 30 years old, and you've had more than your share of experiences, but you are treated as if you were a child.
Here the doctor coerces him to conform to the procedural criteria of the normal category "young spinal injury" (using a wheelchair) by teaching him the organizational view of the normal behavior of his "type of case."

Besides a lack of "normal" emotional display, the other type of miscalculation of progress of labor comes in cases of women who give birth more quickly than is normally expected for the number of children they have had. Again, women who are delivering for the first time (primigravida) are assumed to take longer. However, "natural childbirth" patients often take less than the "normal" time, apparently because of the absence of anesthesia and analgesics which may slow contractions and their supposedly efficacious breathing-relaxing techniques. Thus, staff's assumptions of the normal labor patient seem based on their beliefs and experiences of the "typical patient" as one who experiences a good deal of pain in labor, requires anesthesia, and must be instructed on how to relax (not "struggle") during early stages of labor and to push in the prescribed manner in the second stage of labor in the delivery room. For example, here is a case of a "natural childbirth" patient who found that nurses scheduled their pelvic examinations according to how long they believed she, a primagravida, would take to deliver, as well as how much "emotion" or "pain" she displayed. Such scheduling permitted them to deal with their heavy work load by reducing the amount of time they had to spend with each patient.
At the hospital, I had strong contractions for only about the last hour. They were uncomfortable but not unbearable. From my reading about the Lamaze method I did try to relax. I wasn't scared but I do remember feeling very lonely and wishing someone I knew could be with me. The nurses were very busy and did not think I was progressing as quickly as I was since this was my first delivery and I had not been there very long. I was also being quiet. After checking me, they rushed me to the delivery room. My contractions were stronger and closer together but I certainly wasn't in a lot of pain or about to lose my head, except I was rather frustrated about not being allowed to push. I remember feeling a lot of pressure below and the strong urge to push everything out that was in! I was never so relieved when they finally let me push and that wasn't until I was in the delivery room and the doctor was at my feet ready to catch the baby.16

When the patient's doctor is already in the hospital and assumes responsibility for monitoring the patient's labor, the nurses in these cases use notions of the progress of "normal labor" to warrant reducing the number of times he must be "disturbed" while he is elsewhere in the hospital sleeping or treating other patients. For example, in this case the "natural childbirth patient" is a nurse by occupation and uses her knowledge of hospital policy concerning those treatments which require the presence or approval of her doctor to undermine the nurse's attempt to teach her the organizational view of the "normal labor" progress which would legitimately warrant "disturbing" the doctor.

"Wake up the doctor," I said brightly. "I think I'm ready to deliver!" The nurses were sweet. "Oh, no, dear, he was just here and you were only 8 cm. dilated, we really can't disturb him for another check so soon." "All right," I said, remembering the doctor had to approve my medication, "I'd like to be sedated." So the doctor came and was equally doubtsful, but I was feeling more and more like pushing and could hardly stop. We rushed to the delivery
room. When we got there, the panting for pushing was perfect and I had two pushes. At that point the doctor said, "Please stop pushing until I get my gloves on. I want some part in this." Finally, one push and Jessica's head came out. Two hard pushes for the shoulders.17

Here the doctor tries to persuade the patient not to push by reminding her of his entitlements as a doctor to take part in the expulsion of the baby ("I want some part in this.") In other words, she is not to regard the delivery simply in terms of expelling of the baby. Instead, it is called to her attention that she should deliver him in the medically prescribed manner by observing asepsis ("... until I get my gloves on.") and the entitlements of the medical staff surrounding her, in this case those of the category "doctor." Again, this shows how the interpersonal management techniques employed by a staff member may serve to prolong "length of labor," just as does use of anesthesia and other means of "physical" intervention.18

At City, I observed similar attempts to persuade the patient to stop pushing on the grounds of allowing time for asepsis or other medically prescribed preparatory activities, such as performing an episiotomy. In fact, these warrants often were dramatically presented to frighten the patient into cooperation. For example, in the following case the patient has begun expelling the baby when the doctor arrives. The nurses have already had her get on the delivery table and instructed her to "hold" the baby from being delivered.

Dr. "Don't push! Just pant!"

Patient: "But I can't help it!"
Dr.: "Don't push, whatever you do! We want to be ready and not have the baby in bed! You're going to be washed. It's going to be cold. Lift your bottom up dear."

Nurse: "You've just been baptized. Ha! Ha!"

Dr.: "Don't push! Don't push! Just pant! Just pant! Thata girl! You're going to feel a needle prick now." (He injects the local anesthesia for the episiotomy; but the baby starts to come out before he can begin cutting.)

Although the patient is already in the delivery room and on the delivery table, the doctor tries to dramatically equate the absence of his preparatory activities with "having the baby in bed," which if it were true, presumably a lay patient would find it unaesthetic or dangerous and therefore adequate grounds to "hold" the baby.

Another common management technique, which was demonstrated to some extent in the last case, is "pressing" the patient with repeated instructions to "pant" or "breathe" instead of pushing and insisting the patient can do it, not accepting any protests of being unable to resist the urge to push. A "natural childbirth" patient relates an example of this method and implies that "natural childbirth" training would already give the patient the skills to breathe, pant, and not push which would enable her to avoid being "pressed" and cajoled to learn to use this technique during labor itself.

We (she and her husband) could hear a lady yelling and crying from down the hall. Two nurses were telling her to breathe deeply, to keep from pushing before the doctor arrived. The lady kept saying she couldn't and the nurse kept insisting she could. I was glad not to be in the same situation. I knew I was able to do something to help myself.
Indeed, from my examination of natural childbirth reports and observations at City, I suggest that the "trained" patient usually received differential treatment in terms of being managed to "hold" the baby. They less often were typified as having "lost composure" or protesting incapacity to not push. Thus, "untrained" patients, the majority, were more frequently treated with this technique of "pressing" and cajoling.

If the doctor takes too long to arrive, these interpersonal management techniques or the patient's own past training may be inadequate to sufficiently prolong labor. Frequently at this time, nurses and the anesthetist try to intercede "physically" by administering a local anesthesia, or an additional dose of it, to slow down contractions even further. In the following case a "natural childbirth" patient relates how her progress in labor was miscalculated by nurses using "normal labor" standards in order to avoid calling the doctor "needlessly." As a result, she has to be rushed to the delivery room. There she follows their instructions to "hold" the baby and gains them ten minutes. However, apparently they have to administer several doses of local anesthesia (epidural) in order to avoid having to deliver the baby themselves.

Contractions were two minutes apart and lasted 75 to 90 seconds. I used accelerated panting at this time. The nurse gave a rectal exam and said I was 2 cm. I was scared. I felt if contractions got any stronger I wouldn't be able to control them. I asked to see my doctor. The nurse didn't want to call him until I was at least 3 cm. Well, I got this sharp pain around the bladder so I decided since I was only 2 cm. I'd better head for the bathroom before transition. I had one hard contraction on the way, two in the bathroom and two on the way back
to bed. They were 90 seconds long and 2 minutes apart. My water hadn't broken yet. Then a little old nurse came in and said, "Stop that breathing or you'll hyperventilate!" Boy, I wasn't going to stop for anybody. I asked her to get my doctor but she wanted to check me first. This was about 7 minutes after the last check. Just then OGGGG, the big push came and all the nurses ran in. I remember saying "What's the matter with me, I'm only 2 cm. and these contractions are OUT OF SIGHT!" They rushed me to delivery while I was trying to wave good-bye to Ron (the husband). I was so happy because it was so easy. The doctor hadn't arrived so I was told to lie on my side--knees together and to pant and hold the baby. I did my best for 10 minutes but his head was coming out and the nurses were panicky. I told them to do what they felt was best. Well, I got an epidural again. That stopped contractions until the doctor arrived. I delivered Gregg with two easy pushes while watching him being born. Dr. Gallivan was very nice. He had delivered many natural births in Europe but felt that medication was best at the end of the second stage. The nurses thought I did beautifully. If only they could have diagnosed my dilation correctly and if the doctor had been there I could have delivered Gregg in two pushes with no epidural at all! Looking back . . . I will always believe what I feel and not what I'm told.20

This "natural childbirth" patient locates the cause for her "failure" to deliver quickly and without anesthesia in the "incorrect" diagnosis of her labor which lead the nurses to delay "bothering" her doctor. This experience results in her resolve to ignore nurses' diagnoses in future deliveries (". . . always believe what I feel . . ."). Again, this demonstrates how these patients from their past experiences in hospital context or from exposure to "natural childbirth" lectures and literature may begin treating their progress in labor and its warrantability as grounds to summon their doctor as a cross-cultural issue. This approach may result in explicitly conflicting with staff on this issue or developing devices to undermine their control, e.g., by asking for treatments
that require the approval of their doctor.

Finally, a private obstetrician relates his concern to maintain a "normal work day" with the consequence that, as he puts it, the patient "should not expect the doctor to be in constant attendance from the onset of labor." Also, he describes the function of the nurses to monitor labor by orienting to "normal labor" characteristics (after all, they "have seen a lot of women in labor") to permit him this freedom to manage the rest of his work load and/or his "personal life." However, here he condemns the practice which I found common at City and in the "natural childbirth" reports of "holding" the baby back on grounds of the possible adverse effects this practice may have on the baby in the "birth canal." Finally, he shows how the staff may collaborate with the doctor to ensure that he will give a visibly competent performance for the waiting relative and patient if this monitoring and "holding" process fails to provide for his timely arrival for the delivery.

It's not unusual for women to fear their doctor will miss the delivery. Of course, no patient should expect the doctor to be in constant attendance from the onset of labor. He may be in the operating room, or with other patients, or sleeping. And the nurse who has seen a lot of women in labor doesn't want to wake a doctor at two o'clock in the morning for a patient who's not going to deliver until three the next afternoon. But occasionally they make mistakes. I've had a resident or nurse phone me and say, "Your patient, Mrs. So-and-so, just came in and she looks like she's got about four hours to go." So I roll over and go back to sleep, or continue seeing patients, and suddenly I'll get a frantic call: "Your patient's ready for delivery."

I'll say, "I'm on my way, but if I'm late, don't you hold the baby back."
This is actually done in some places. The lady's about to deliver and the doctor's not there, so that baby is literally held back—or the nurses will cross the lady's legs. The baby is in there trying to be born. It may take two or three breaths in the vagina, where there isn't any oxygen, and may suffer brain damage. It's inexcusable to delay delivery. There's always somebody at the hospital who can take over.

We don't miss many deliveries, but anybody who's in obstetrics misses an occasional one. I've never faked it, but there are some doctors who do. When the patient is ready for delivery and her doctor isn't there, she's given some anesthesia that puts her out and she is delivered by a different obstetrician. Then her own doctor comes roaring in with his white coat on, takes some blood—there's always plenty of blood around, with the placenta and episiotomy—and he smears it over him and acts as if he's just finished the delivery. He walks out to greet the father and says, "It's a boy." I've seen it done.21

Medical students and young doctors also use this device of altering their appearance to convey to colleagues and superiors their recently gained experience and competence. After an operation or delivery, for example, they often wore their blood stained surgical gowns to the hospital cafeteria, whereas older, more experienced doctors changed into their business suits or white hospital pants and jacket immediately after a delivery.

Another way that interpersonal management techniques serve as a resource to control "length of labor" is in their use to "pressure" the patient to follow medically prescribed methods of pushing with each and every contraction or "pain." For example, the following case observed in the delivery room at City shows how staff may increase this "pressure" in order to try to shorten labor time so that they meet the demands of their work schedule.
Nurse to Intern: "We'll have to teach her how to push."
(The patient groans a lot.) "Go to the bathroom! Get right down and push!" (Patient screams and complains about the pain.)

Dr. to Patient: (as he taps her on the chin with his fist) "No noise now! No noise now! Just push!" (The anesthetist puts the mask over her mouth when she tries to yell again.)

Nurse: "Breathe and push to get maximum diaphragm pressure."

Dr. "Are you ready to push?" (patient yells and complains about the pain.)

Nurse to Dr. "She's not really pushing."

Dr. to Nurse: "I can't see the baby." (He is doing a pelvic examination.)

Nurse: "She's not pushing." (The doctor and the rest of the "delivery team" leave the delivery room for a coffee break.)

(After ten minutes two nurses return. One stands at the end of the delivery table and, like a cheer leader, yells at the patient.) Nurse: "Hold you breath and push! Hold your breath and push! Much better! Push! Push! Very good!" (She addresses the other nurses) "This is her second baby, so labor (the push stage) shouldn't last more than one-half hour and often only ten to thirteen minutes. I do believe she's started to deliver. Push! Push! One more. That was very good! Ok. Now rest." (Nurse listens for the fetal heart beat and quietly tells the other nurse off to the side of the table) "It's not really strong. It's tight" (the birth canal). (patient loudly groans again) "No noise! A long, long push." (the doctor reenters the delivery room.)

Dr.: "If she's not pushing, put her in bed."

Nurse: "She's pushing, but the baby is not getting lower" (says this quietly).

Dr. "I am needed over at Metropolitan Hospital . . ."

Nurse: "I wouldn't do that."

Dr.: "How often is the pain?" (contraction)

Nurse: "Every three minutes." (Patient loudly groans.)
Dr.: (roars at the patient) "Keep your mouth closed and push a little harder!" (The nurse smiles and seems amused at this sudden interest on the part of the doctor to "pressure" the patient to push even harder.) (He addresses the nurse) "Yeah, it shouldn't be too long. That's my girl! It won't be long now! It won't be long now!" (Patient continues to yell and exclaim at the pain.) "Ow! Yeow!"

Anesthetist to Dr.: "Do you want any anesthesia?"

Dr.: "Not just yet." (The nurse puts her hand over the patient's mouth when she screams.) "Ok! Ok!"

Anesthetist: "You did very well!" (The baby cries when it is expelled.) (In a hurry to leave, the doctor pats its bottom perfunctorily, cuts the umbilical cord, and hands the baby to the nurse.) "It's all yours."

Nurse to Dr.: "They left her alone for a few minutes and then she pushed. I guess she was scared."

The doctor refuses to give any more anesthesia, although the patient complains loudly about pain, presumably because it may prolong labor and he is in a hurry to leave. The doctor also tries to step up the patient's efforts by roaring instructions at her. He seems concerned to meet his work commitment at Metropolitan and will put the patient back in the labor room if delivery does not seem imminent. Staff had taken the lack of progress early in the pushing stage as an opportunity to take a coffee break, leaving the patient alone in the delivery room. At the conclusion, the nurse suggests that this may have inadvertently served to reduce labor time because the patient may have found their vigorous "teaching" frightening. Thus, the scheduling of this "pressure," as well as deliberate attempts to intensify it may affect the "length of labor" besides any supposed expectations (according to Rosengren) a
patient may bring to the hospital with regard to playing the "sick role" in labor.

Generally, with regard to management techniques, I found two somewhat different approaches. The senior consulting obstetricians who also taught at the hospital, as well as some of the younger, more highly trained nurses, followed a different approach to "teaching" patients to push than did the rest of the doctors, most of whom were general practitioners and some staff residents. The above example of "pressuring" the patient in order to shorten labor time was typical of the approach used by most of the doctors. In the following remarks to me, Dr. Bartlett contrasts his approach with that one.

The delivery room is too antiseptic. There's no T.V., flowers, or radio. Nothing to distract the patient. The average patient is not prepared or trained for delivery, so they get confused, disoriented and disorganized when she's being shouted at by six different people, giving different instructions. Masks scare them (for anesthesia). They distrust it. It disorganizes and confuses them. When I deliver, I make everyone shut up and I do all the talking so the patient has someone to focus on. Also, it's sometimes better if everyone leaves the room rather than pressuring the patient to deliver. Some nurses are nicer than others. The older ones, especially, are callous and order the patient to push the baby out. They are the cheer leader type. They think they are important and they are delivering the baby and don't like to leave the delivery room. Some of the younger, more educated ones are more quiet and come and go rather freely since they know it's the woman who's delivering the baby. Most of the nurses are not trained in aiding contractions. There's just a poor organization in the delivery room. A lot of student nurses, a lot of people running in and out and around the table. Everyone tries to get in some words to the patient. I have never been able to understand why the delivery room is organized this way with total chaos.

An intern described to me this approach in similar terms.
Dr. Bartlett and some of the others believe the mother has the baby and does most of the work. But here most of the doctors follow a different technique for the labor. Some will leave the room occasionally, but most will stay and keep encouraging the mother to deliver.

I might add that most doctors usually leave only to meet the demands of their work schedule or for leisure, (e.g., a coffee break) rather than as a deliberate technique to speed up delivery by letting up on the "pressure" put on the patient to deliver. Thus, the "length of labor" that a patient experiences may depend on her doctor's approach to patient management and work schedule as much as any conceptions she might have about acting "as if sick" in labor, as Rosengren assumes.

Thus far I have attempted to show how the organization of staff's occupational routine, especially their management techniques, can strongly influence the events in labor Rosengren calls "difficulties." I have engaged in this discussion to demonstrate that an adequate analysis of such "medical" or "physiological" events requires an ethnographic approach whereby the routine organizational procedures that constitute them are examined, as opposed to a structural survey approach which ignores their constitutive properties. Now I would like to turn to a more detailed description of management methods used by staff in the delivery room.

As I have just described above, I found two rather different management approaches in the delivery area. The approach used by Bartlett and some other teaching obstetricians starts with the same assumption about the typical or normal
patient in labor as did the more prevalent approach: she lacks the training and proper "frame of mind" to be self-guiding in effectively pushing. Most of the staff, including the private general practitioners, persistently "pressured" the patient to deliver from her arrival in the delivery room until the baby was expelled. As Bartlett indicated, they often used such methods as cajoling, name-calling, scaring, sanctioning, and issuing authoritative commands to deliver. On the other hand, Bartlett and others usually refrained from what he calls "callous" and "authoritative treatment" and allowed the patient more time to push unassisted. I take it that this approach follows from Bartlett's and other teaching and consulting obstetricians' familiarity with the professional literature advocating the implementation of ideological "patient as person" ideals and psychotherapeutic principles in labor "coaching." Indeed, they did seem more concerned to observe the patient's lay sensitivities by not shouting at the patient and trying to be less "authoritative" and "callous." This approach seemed based on the ideological ideal model of the patient as an active participant ("... she's having the baby."). On the other hand, most of the doctors tended to treat the patient as a passive child requiring strong authoritative guidance and constant, rigorous "pressure" ("cheer leading") to deliver expeditiously and safely. This approach probably reflects practical work concerns vis-a-vis scheduling and visible competence to a greater extent than does that of
the obstetricians. It is more "job located" or "setting specific" than based on any professional medical or academic ideological position.

Coerced Cooperation

To describe the "pressure" techniques of the more prevalent approach I would like to provide several examples of each of the methods mentioned above: commanding, cajoling, name-calling, sanctioning, and frightening or scaring the patient.

Commanding simply entailed one or more of the staff authoritatively and loudly ordering the patient to deliver the baby with her next pushing efforts.

Dr.: "Ok, Dorothy. Let's have this baby!" (To Nurse) "Ok. lift her up."

Nurse: "That's the one (push) that did it, eh?"

Dr.: "No. Maybe next time."

Patient: "But I can't breathe!"

Dr.: "That's ok. I got it." (The baby is finally pushed out.)

................

Nurse: "Push!"

Patient: "I'm pushing!"

Nurse: "Push! Push that baby right out! Much longer!"

Patient: "I can't do it again."

Cajoling is another commonly used method when the patient is viewed as being "negligent" in helping to push the baby out.

Nurse: "Come on, you! Push! Push it out!"

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Dr. (sarcastically): "You can be a help by pushing a bit!"

Nurse: "She's not really pushing."

Dr.: "I can't see the baby. Are you ready to push yet?"

Name-calling may be resorted to when the patient does not respond "sufficiently" to the staff's commands to push.

Dr.: "Bear down, please. Push! Push that baby out! You're a lazy thing!"

Also, the patient may be slapped, severely reproved or sanctioned for "lagging" in her efforts to push as staff instruct, although this may be due to the effects of drugs the staff have given.

Dr. (sarcastically) to Nurse: "She gets a nice relaxation from the epidural."

Nurse: "Keep it up! There's still a contraction!"
   (slaps the patient) "You're fast asleep! It's (the baby) going to come this time.

Nurse (to a "lagging" patient): "Don't you dare stop pushing or else you'll get spanked."

A "natural childbirth" patient reports how she was reproved for apparently "losing control" and refusing to cooperate in pushing as instructed. She attributes her "uncooperative" behavior to her disapproval of this hospital's routine of excluding her husband from the delivery room, who most "trained" patients are taught to depend on for effective labor coaching rather than staff, who usually aren't trained or concerned to do so, especially in the early stages of labor. This was also the case at City.
things moved quickly—and nearly left me behind. I was expecting to lie in the labor ward next to the delivery room for a couple of hours, breathing away. The nurse said: "Let me know when you feel the baby is pushing down in the back passage," and the next thing I knew, he was. So up I got and walked into the delivery room and clambered onto the table. I asked for my first shot of pethidine at this stage—about 3:00 p.m.—as the pains in my back—were getting a bit excruciating, though not unbearable. With the second shot, about 15 minutes later, which I didn't ask for, I went off into a kind of drunken stupor, which I regret. However, I was able to arouse myself when necessary and interrupted the nurses' conversation with a peremptory: "Here comes another one" or "Hold my foot please," or "Can someone hold my head up?" If James (her husband) had been there, he could have done these things for me, and would also have encouraged me to be more awake, I think. As it was, the drug seemed to release rather hostile feelings towards the doctor and nurse for not allowing him to be there, and I even took a perverse delight in not pushing when they were telling me to. I had negative rather than positive feelings, which probably slowed the labor down.

I certainly wasn't at all inhibited emotionally in the delivery room and called variously on God, James (several times), and the baby—to get a move on. "It's no use you telling the baby to get a move on," the nurse reproved me. It's you who should be getting a move on—come on, push!" "I am pushing," I roared, so loudly they must have heard me at home.22

Finally, an apparently common method used to get the patient's cooperation with staff's instructions was that of scaring or frightening the patient with the possibility of a lengthy, exhausting labor or "complications" which threaten the baby's welfare. For example, a "natural childbirth" patient reports how she was repeatedly reminded every time she didn't push with a contraction that she was lengthening her labor. She reports that her lack of cooperation, however, was due to the drug (a pain killer) which was "forced" on her.

By this time the Demerol had taken effect and I was dozy. I felt ineffective in my pushing and the nurse said I was doing it wrong and that it should be "like a bowel movement."
I stayed on my bed quite a while before they had me move to the delivery table. I remember having a very, very dry mouth and finding it difficult to understand what they were saying to me. Following directions was particularly hard, especially trying to push like they wanted me to. I also found it difficult to push through the contractions and would stop and pant. The nurse kept telling me that every contraction that I didn't work with would make it that much longer.23

Similarly, a doctor graphically reminds a "natural childbirth patient of the possibility of having to do a forceps delivery (risking damage to the baby) after she had been given a local anesthesia unless she pushes effectively and a great deal. Again, after persuading the "natural childbirth" patient to accept a local anesthesia on the grounds of her baby's welfare, she is still held accountable for a rigorous and effective pushing effort.

... I just wanted to sleep. Bill (her husband) said every time I would push he could see the baby move down and then come back up when I stopped pushing. The nurses were very supportive and commented on how relaxed I was when not pushing. I was laughing inside, thinking, "Oh heck ladies, if you were as tired as I, you'd be very relaxed too!" If I could have spared the energy, I would have told them. The doctor said that it would be better for the baby if I had a saddleblock, since her head had pushed against my rectum for so long. So at 2:50 I had one and at 2:56 Kimberly was born, without instruments or nurses' pushing (on her abdomen). The doctor had said, "Remember, the more you push, the less I'll have to pull." With those words, I pushed with more energy than I'd used in nine hours of labor.24

Finally, a patient at City is informed in graphic, technical detail of her baby's "condition" in her uterus, referring to its "low heart beat" and "pressure on its head," to appeal to her assumed concern for the baby's welfare.

(The patient is draped and given a local anesthesia.)
Nurse: "Can you feel any more contractions?"

Patient: "Yes."

Dr.: "How long has the block (local anesthesia) been in?"

Nurse: "20 minutes."

Dr.: (to patient) "If you could listen to the fetal heart beat, you would find it's low after you've ruptured your membranes because there's pressure on the baby's head. So, with the next couple of contractions please push to bring its head down! Push as hard as you want. The anesthesia has taken hold."

Earlier I described how most of the staff are concerned to use anesthesia and interpersonal management techniques to quiet "noisy" and "complaining" patients. Generally, I found that they used the same management methods to teach her to be a "good patient" while experiencing the "stress" of labor so as to "pressure" her to be a "good pusher": commands, sanctioning (verbal and physical), cajoling, chastising, and invoking the welfare of the unborn baby.

Most frequently, when a patient is perceived as having "lost control," she is commanded to stop making what the staff pejoratively call "noise" or "to get control of herself."

Dr.: "Now it's (the contraction) coming. Push hard! Again! Again! Again!"

Patient: "Help me! (starts crying) Please help me! I'm too tired! I don't think I can push any more!"

Dr. and Nurses (loudly): (when she starts to cry) "Sh! Sh! Sh!"

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Patient: (groans loudly) "Help! Help!"

Nurse: "No noise! A long, long push! That's the way! Push! Push! That's the way, right down!"
Dr.: "Don't push yet, Mrs. ___, please! You'll feel a little prick." (Local anesthesia for the episiotomy)

Patient: "Ow! Ow! Dr. Please help me!"

Dr.: "Do you want to push now? Give a push!"

Patient: "Give me some . . . Ow! Ow!"

Dr.: "All right! Come on! Let's have it all under control!"

Patient: "Ow! Ow!"

Dr.: "Now, Mrs. ___. Come on!"

Patient: "It feels like it's ripping!"

Dr.: "It's not! Put your bottom on the table! Give one big push and put your bottom on the table! Come on! Come on! Mrs. ___ push! Push this baby out!"

If a patient persists in making "noise," then staff may physically sanction or try to stifle her.

Dr. (as he taps her on the chin with his fist): "No noise now! Just push! No noise now! Just push!"

Patient: (screams) "Help!"

Nurse: (puts her hand over her mouth)

Dr.: "Ok! Ok!"

Anesthetist: "You did very well!"

Another commonly used device involves cajoling the patient to "control" herself by pleading with her to do so.

Patient: "Yeow! Ow! Ow!"

Dr.: "Lois! Give a poor Jewish boy a chance!"

Patient: "Yeow!"

Dr.: "How about a Catholic boy?"
Here the doctor and patient are members of the same ethnic category, "Jewish." He uses this as a resource to plead for her cooperation on the grounds of ethnic loyalty. When the patient persists, out of exasperation, he shifts ethnic category (Catholic) to make a facetious plea.25

In another case, the doctor's plea is based on the patient's presumed desire to please her personal physician, who is on vacation. Apparently, the doctor sees that categorical relationship (personal physician-patient) as having more moral force than the current, temporary relationship in terms of persuading the patient to control her expressions of pain and other complaints.

Patient: "Ow! Oh, my legs feel so funny! Yeow!"

Intern: "That's the peridural." (a local anesthesia)

Dr.: "If you can really, really bear with me a while, Dr. Conrad (her personal physician) will be happy."

Another technique involves chastising a "bad patient" and teaching or convincing them that there is no acceptable warrant in their physical condition for their "noise." Also, staff may promise that the labor will be over soon in order to placate the patient.

(Doctor puts his hand on her abdomen to feel for the next contraction. The patient apparently complains about a labor pain and he treats it as a reaction to his hand and therefore grounds to claim it is unwarranted.)

Patient: "Oh! Oh!"

Dr.: "What do you mean Oh! That's my hand!"

... . . . . . . . . . .
Patient: "Ow! Ugh!"
Nurse: "Contractions gone now, Mrs. ___ ."
Patient: (screams) "Yeow!"
Dr.: "You're ok! It'll be over soon!"
Patient: "It hurts too much!"
Dr.: "Just breathe, normally, slowly."
Patient: "It hurts too much on the top!"
Anesthetist: "Just breathe and push hard! Keep pushing!"
Dr.: "Now it's (the baby) coming! Keep pushing!"

Patient: "Oh! Oh!"
Nurse: "It's all going to be over with in a very short time."

In a case where a patient continues "complaining," even after the delivery, while the placenta is being expelled the doctor tries to convince her that she should "control" herself by normalizing the sensations she is experiencing; implying, thereby, they do not constitute adequate warrant for a "loud emotional diaplay." Also, in this case the doctor tells the patient that she is "all through," though she has yet to be instructed to push out the placenta (the third stage of labor).

Patient: "The pressure is building in my rectum!"
Dr.: "It's contractions."
Patient: "Please, where is the other doctor?" (the anesthetist)
Dr.: "You're all through now! Push!"
Patient: "I can't any more!"
Dr.: "That's the after birth and you're all through!"
Patient: "Oh, it's such hard work. It's coming again!"
   No more! No! A lot of pressure against my rectum!"

Dr.: "You're going to have them after contractions, everybody does. You're ok! You're hard to convince!"

With "natural childbirth" patients, I have found in examining their reports that staff chastised their complaints or "noise," using as a management resource the patient's own refusal to accept the anesthesia, which the doctor usually tries to convince them to accept. These cases also illustrate how some staff in some hospitals (not City) regard the use of anesthesia as a cross-cultural issue wherein they try to persuade the "natural childbirth" patient to accept the anesthesia which they assume the "normal labor" patient "needs" and should have to prevent "emotional displays" and "non-cooperation."

Thus, when the patient "complains" about labor pain or painful treatment, these doctors are quick to point out it is in fact the patient's responsibility, since she refused anesthesia. They seem to use the fact of the expression of pain as an "object lesson" on the advisability of using anesthesia, as well as chastising her to control her complaints.

The doctor gave me a local anesthetic prior to stitching me up. In spite of it, I still felt a number of the stitches, and I told him so. "If you'd had a spinal you wouldn't have this problem," he informed me. "But then the baby wouldn't have cried on the way out," I protested. "That wouldn't have made any difference in her crying," he said. So I tried a different approach. "Then I couldn't lie on my stomach right away." He had to agree with that one, although he obviously thought it was a minor consideration. Although we didn't discuss it, there is another reason I am glad I didn't have a spinal—several of my friends have had very severe headaches in the days following delivery, headaches caused by the fluid injected into the spine. I had no anesthetic and felt fine.26
I wasn't allowed to nurse Brian on the delivery table, but we watched the nurse take care of him while I was being stitched (for the episiotomy). It seemed like that took forever. My legs were trembling with fatigue and were most comfortable in the stirrups. I kept saying "ouch" to Dr. G. about his needlework until he gave me some more novacain, and he teasingly made some remark to Carl about how if we knock the ladies out, we don't have to listen to all this complaining!27

Finally, the patient may be taught that she must accept or "put up" with the pain because it is in some unspecified way efficacious in the progress of labor. Here, apparently staff is drawing on the assumed concern the patient has for the welfare of the baby to persuade her to be silent and accept the labor pains.

Patient: "It hurts! Ow! Yeow!"

Resident: "You have to put up with it. This is labor. If you don't have pain, the baby won't come down."

To support my descriptions of the more commonly used management techniques to control emotional expressions, I would like to cite the report of a husband of a "natural childbirth" patient. He suggests how women may be at least partly motivated to become "prepared patients," via natural childbirth training, so as to gain "control" over their emotional expressions in labor and thereby avoid provoking a hospital staff to use the sort of strong interpersonal management techniques I have described.

... As it turned out, we became quite enthused with the method, and we followed through with it entirely in the birth process. Upon reflection afterward, we discovered one equally important, perhaps more important, reason for
which we would do it over again and commend the method to
others. That means in this method there is a built-in
human factor. The wife is in control of her emotions, and—
because husband and wife work together—the couple find
that they are treated as participants in the birth of their
child. In every case our questions were answered. In
every case, after the doctor's examination, he summoned me
back to the labor room and told me about her condition
and what to expect. The nurse was very helpful. She kept
us informed of progress, answered questions, and frequently
gave words of encouragement. This was a far cry from what
went on in nearby labor rooms. There we heard shrieks from
women who were "knocked out," and the response of hospital
personnel to them consisted of remarks such as, "Oh, hush!
You're not so bad off."28

Earlier, I discussed how Bartlett and other senior
obstetricians followed a different approach than most staff
members to dealing with "bad patient" reactions to labor.
Rather than using anesthesia or the management techniques
described above, they tended to permit patients to make these
displays. In following their approach, however, often they
felt it necessary to correct other members of the "delivery
team" who try to "quiet" patients and even counter them by
positively encouraging the patient to "express her emotions."
For example, crying in labor is a frequently sanctioned
behavior in the delivery rooms. In the following cases,
Bartlett and another obstetrician encourage patients to cry
to compensate for the sanctioning efforts of nurses and interns.
In some cases, the "chastised" subordinates revise their treat-
ment, as a result, and also encourage the patient to cry.

Nurse: "Are you still crying? You're going to be all
cried out! Did you cry like that with your first
baby?"

Dr.: "Good thing to have a cry! Want a kleenex?"

Nurse: "You cry."
(Patient starts crying) Intern: "Do you feel ok?"
Patient: "Yes, just having a little cry."
Intern: (sarcastically) "A little comic relief then."
Bartlett: "Have a good cry! Give her a kleenex."

Regardless of approach, when the delivery is completed, the staff usually praise the patient's performance, even though they may have found it sanctionable. Apparently, this is done so as to "save face" for the patient and encourage her to take a positive outlook on her delivery experience. I found that staff are morally concerned to have the patient enthusiastically accept and welcome the baby as hers. Thus, they try to persuade her to have a positive outlook on her delivery behavior to get her in the prescribed frame of mind to receive the baby. Besides simply praising her for being a "good patient" in delivery, even when they found she was not, the staff are quick to correct any negative assessment proffered by the patient.

Patient: "I was shouting so much, wasn't I?"
Dr.: "No. Hear those other girls shouting? That's what I call shouting!"

Here the doctor tries to persuade her to view her performance positively by offering criteria for "shouting" which he claims exclude the patient's performance from being so categorizable. This patient has been screaming and crying, too, but the doctor corrects or redefines the category she uses to characterize her performance. In the process, he establishes a contrast conception of "shouting" girls which he claims warrants redefining
her behavior from the negative description she offers. This same "face saving" technique of establishing contrast conceptions in order to redefine the patients' behavior or condition was also observed in the clinic where staff try to redeem the moral character of unwed Home girls by flatteringly contrasting them with other "less clean" girls who come to the clinic.

In the management of pushing, Bartlett and several senior obstetricians generally avoided these strong "pressure" methods described above. Instead, they relied more on repeated reports to the patient of how much progress she was making with her pushing efforts (even when she was not) and approving and praising remarks on how well she was performing her pushing job (again, even when they thought she was pushing "ineffectively"). The rest of the doctors also used these techniques, but interspersed between the stronger "pressure" methods. These praising remarks were even used in the labor rooms, apparently to guide the patient to have the prescribed optimistic outlook on her usually long, arduous task. "Natural childbirth" reports provide some supporting data for the observations at City.

11:45 a.m. After twelve hours of labor, my doctor's associate came in to subject me to another grinding, twisting examination.

"You are doing just beautifully," he said. "How far am I dilated?" "3 cm." "3 cm.," I said. "My God, no progress at all--I was 3 cm. three damned hours ago!"

He gave me some cheery talk about the head having worked itself in the proper position against the cervix; he said that labor would become more effective very soon and that I would have to be taken up to the delivery room presently.29
Here the doctor tries to revise the patient's criteria of progress as simply being the amount of dilatation of the cervix. He tries to point out the "engaged" position of the baby's head as a significant sign of progress to compensate for the obvious slowness of her labor and promises more significant progress will occur very soon. In another example, the doctor sanctions the patient as having no grounds for being disappointed at no progress because she should just be satisfied with her "easy time" in labor. Apparently, he is concerned with teaching her the proper outlook on labor progress: one of constant cheerful optimism.

The contractions were now intense, coming every minute and fifteen seconds and were mostly felt in the lower back. I was very sure that I was in the transition phase and started the pant-and-blow breathing. I was utterly crushed when the examining resident said that I was still 6 cm. dilated and nowhere near transition. (I wish I had realized that two doctors can give entirely different evaluations of one's progress. As my doctor explained later: "One man's 6 cm. is another man's 8 cm.") At any rate, this resident insisted that I lie flat on my back and proceeded to give me a lecture on being grateful for having such an easy time. I suppose he had a point, but I didn't feel like hearing it just then!

Another technique involved attributing the lack of progress to the yet unknown or non-existent non-pathological attributes of the baby itself, including its "character" or gender. Here, a "natural childbirth" patient shows how this was used, in conjunction with promises of increased significant progress in the near future.

At 3 p.m. suddenly the contractions stopped. I slept seven minutes. I was having difficulty with sleeping
through until peaks, but Gary (her husband) timed carefully and warned me. Awake at 4 p.m. Contractions have increased in strength but not length nor have the internals (examinations) decreased. Dr. Grolber checked me at 4:45, said only 2 cm. still but as soon as I went to 3 things would speed up. He said there weren't any problems, merely a slow baby.31

I found this to be a common practice in the clinic with patients who were "overdue" to deliver and concerned about some pathological cause.

Resident:  "How are things today?"
Patient:  "Ok."
Resident:  "Stalling a bit, eh? You've gained 40 pounds? Is your baby active?"
Patient:  "yes."
Resident:  "You're sure of your dates (of conception)?"
Patient:  "Yes."
Resident:  "Where do you feel the baby kick? Up here?"
Patient:  "I don't know."
Resident:  "The baby gets lost. Ha! Ha! I'll check for it. Everything is fine. You're not over very much, just a couple of days. You may go into labor at any time, if I don't see you next Friday to see how you are. If it's a girl, they're slow and they like to make you wait."

Here the resident attributes the "slowness" to the behavior of the fetus, as if it possessed adult sex-appropriate traits. However, if an "overdue" patient returns several times, this device may be called into question because it becomes a source of faux pas if the resident forgets or makes a mistake as to which sex he had used to "explain" the delay on the previous visit of a particular patient. For example, this occurred
with a patient who apparently had been told that her delay was due to the gender-appropriate behavior of the fetus.

Resident: "You're not over very much. Two days. Less than five percent deliver on the estimated date. You don't want to deviate. You certainly look ready. It must be a boy . . ."

Patient: (cuts his utterance short) "You said it's a girl last time. It's slower, so it's a girl."

Resident: "Hard head like a boy. Head way down here. Lots of beds upstairs so any time you want to come in we'll be happy to have you."

The resident tries to "repair" his faux pas after the patient corrects him by implying that he was only trying to guess the baby's sex by its apparent physical attributes ("hard head") rather than trying to "explain" the delay in delivery. Note that in addition to the sex of the fetus, he tries to normalize her delay by positing a statement of probability whereby being "overdue" can be characterized as "normal," if only on statistical grounds.

In the delivery room at City, the patient was diagnosed as making good progress in her pushing, and praised for her performance even when neither was the case.

Nurse: "Ok, dear. Push!"

Patient: "I don't want to push."

Nurse: "By one or two contractions you probably can."

Dr.: "Ok. It won't be long. You're doing fine!"

.............

Nurse: "Push! Hang on! Good girl!"

Patient: "I'm getting tired."
Nurse: "I'll bet."

Dr.: "You've been very good!"

Besides general verbal assurances, staff try to provide more concrete evidence that the pushing is effective by promising or describing the movement of parts of the baby, usually the head. This usually occurred in the later stages of pushing when the baby was in the vagina. However, a natural childbirth patient reports a device whereby staff tried to give an observable indication of the movement of baby early in the first phase, prior to pushing.

A very nice nurse, Mrs. C., prepped me, cranked up the bed, told me she had been impressed with two of our other students who had been there a week ago. Best of all, she said it was okay for Dan to come in, since I was the only one in the labor section. The intern who checked me said I was 4 cm. dilation--very encouraging news--nearly half dilated and I felt great. Mrs. C. came in periodically to check on the baby's heartbeat. Each time she put an X on my tummy, which was very encouraging because each time it moved down.32

Also a report illustrates how a patient may be promised results very soon in terms of observable movement, when in fact she has a good deal more time to go until delivery.

At about 1:40 the nurse told me that in just a few more pushes we would be able to see the baby's head. I was overjoyed with thoughts of a 2:00 delivery. But the nurse went away and didn't even come back to check for a half hour or so. By about 2:20 the head was starting to appear when I pushed.33

At City, staff would continually and closely examine the "birth canal" during the later phases of labor in order to be able to report the first visible evidence of the baby, although the baby may be still quite high in the "canal." In fact, with
each push, they may claim to be able to report more "progress" in terms of more of the baby's head becoming visible.

Patient: "I can hear you, still, so keep telling me what to do!"

Nurse: "I'm going to put this on your tummy. It's heavy but it's necessary to listen to the baby."
(patient groans)

Dr.: "That's a girl."

Patient: "Please don't stop telling me! In the middle of it (contraction) keep telling me what to do so I can concentrate on it!"

Dr.: "Hold on to the hand holds. It'll help you to push. We can see a little hair down here. Hang on and push hard and hold on to the bars! That's it! Good! Tremendous! Great! There's a girl!"

Patient: "Oh, doctor!"

Dr.: "Ok! It won't be long! Good! Each time you push like that, I see more hair!"

Finally, when the baby is down far enough, they hold the mother-to-be up to look in the mirror on the wall at the foot of the delivery table, so that she will see the movement that they are reporting as soon as it is possible.

Dr. to the husband: "The baby is in the easiest position--face to the back of mother. Come and see the scalp in the mirror."

Nurse: (holding the patient's head up) "That's good! the baby came down wonderfully that time."

Dr.: "She sure did!"

Nurse: "You can see the baby when born, eh? Ok, push down. Help your baby!"

Here they also membership the baby as the patient's to appeal to her assumed concern for its welfare. ("Help your baby!")
When the baby has been delivered the staff typically praise the patient for a good job of pushing even though she may have been sanctioned as a "lazy" or "poor" pusher. Presumably, this effort to "save the patient's face" serves to keep her in a positive frame of mind when she is presented with the baby.

Patient: "I have been doing all the breathing exercises in prenatal class, but all those pains came."

Dr.: "You did a good job. You pushed for two hours."

Patient: "When you give me that good Demerol (pain killer) time moves quick."

Dr.: "First class! You get a gold star!"

Sometimes younger staff members, student nurses, doctors, and interns vary from this practice. Apparently due to their inexperience, they will give an "honest", i.e., often negative or "lukewarm," assessment of the patient's performance, which more experienced staff treat as faux pas warranting immediate revision to restore the strongly positive judgment they have been giving throughout labor. For example, here an intern offers only a neutral or "lukewarm" judgment of a patient's performance which is quickly corrected by the doctor.

Patient: "How did I do?"

Intern: "Ok . . ."

Dr.: (cuts his utterance short) "Ok! You did your job!"

During the course of labor, staff accompany their continual praises and diagnoses of progress with efforts to
control or conceal connotations, implications and evidence of a lack of progress or "complications" which presumably would undermine the positive, optimistic "frame of mind" staff is trying to persuade the patient to adopt so she will not stop pushing. For example, when staff discuss the patient's lack of progress and its physiological causes, they do so usually in a quiet manner off to the side of the delivery table or out in the hallway of the delivery floor. In the following instances, staff quietly discuss the patient's problems, but when she asks about her progress the doctor gives her general encouragement.

Dr.: "Good! Keep pushing!"

Patient: "Am I fast enough?"

Dr.: "Good strong fetal heartbeat and everything is fine."

Dr. to Patient: "That's good! Tremendous! Great! (quietly to nurse) Tight pelvis. She's had trouble before. (to patient) There's a girl! (to nurse) She has big spines and relatively narrow arch."

Nurse (quietly): "She's not very big."

Dr. (quietly): "A lot of it is pinning against the spine. Each time it keeps sliding back. Maybe this time it will stay down."

Just as in the concluding assessment of the patient's performance, young staff provide a source of faux pas by their straightforward announcements of their assessments of a lack of progress. For example, in the following case at City, a patient hears the student's assessment told at a fairly audible level to the
doctor. Alarmed, she demands to know her progress. The doctor tries to "repair" this faux pas by treating her inquiry as a matter for humor.

Dr.: "Could someone tell me when a contraction is coming?"

Student nurse (puts hand on the patient's stomach): "Despite all that pushing, the baby has not come down far."

Patient: "How long is it going to take to deliver?"

Dr.: "Another six hours."

Patient: "You wouldn't let me go that long?"

Dr.: "Not unless I was mad at you for gaining weight."

The doctor seems concerned that the patient not take her lack of progress too seriously. He avoids giving her a specific answer, which would be negative, by treating her question facetiously and deliberately exaggerating his assessment. However, the patient does take his assessment seriously and implies that it reflects on his competence if the labor becomes even more lengthy. The doctor's reply seems intended to mildly sanction the patient for presuming to accuse him of negligence: he humorously claims that such a negligence would be deserved by her past transgression against his dietary instructions.

Staff normally tries to exercise similar control over connotations or implications which arise in the interaction in the delivery room related to possible "complications" of the patient or baby. However, here also the younger staff tend to make faux pas which older staff try to "repair." For example, in the following case the doctor tries to prevent a
student's reference to blood loss from becoming a topic in the interaction with the patient.

Dr. to the Nurse: "It's nice not having to do an episiotomy."

Nurse: "Yes. The last one had blood all over the place."

Patient (alarmed): "What?"

Dr.: "Just Dr. talk."

Here the doctor invokes the fact that the staff discuss many "technical" topics in the presence of the lay patient which she would be unable, and therefore not entitled, to participate in, i.e., "doctor talk" from which the inexpert patient may be warrantably excluded. By casting the student's faux pas in this guise, the doctor tries to persuade the patient that the remark does not apply to her case: it is just "technical talk" about which she need not be concerned. In fact, this example shows how a patient may be warrantably excluded as a conversational participant, which in this case permits the doctor to treat her alarmed inquiry as not requiring a reply. In another case reported by a "natural childbirth" patient, a nurse tries to "repair" or revise the frank assessment of progress and complications made by a young resident by offering a general reassurance that her labor was nevertheless "all right."

... What a disappointment! Although I was in real labor, I was only two centimeters dilated. The first resident to examine me nearly undermined my confidence by assuring me that "at your age (nearly 30) the first labor is always very slow." Then he turned to the nurse and asked, "Is she bleeding too much?" and left the room. The nurse patiently and firmly reassured me that everything was just as it should be.34
Besides the faux pas produced by younger staff members, doctors and senior nurses also try to control the connotations of slow progress and "complications" in labor or the newborn child which are introduced by the patient. This occurs when patients mention or query staff on what staff consider "old wives tales." Also, patients who are by profession nurses or midwives may proffer their observations related to "abnormal obstetrics" based on their occupational knowledge or experience. In the following case a lay patient mentions what staff later characterize to me as an "old wives tale" concerning the higher incidence of abnormally large heads among babies of German extraction.

Patient: "My husband is German and we live on the Black River and we see all these German babies with large heads. They're special types or different."

Dr.: "They're big, tough kids."

Patient: "But my husband doesn't have a big head."
(Dr. doesn't reply.)

In order to dispel the patient's apparent fears of her baby having a "German birth defect," the doctor seems to use the method of deliberately "mishearing" what the patient obviously intends by "large heads" and "special types" or "different" as referring to the common-sense shared typification of the physical characteristics of Germans, as being "big and tough." Thus he tries to normalize or redefine her observations of an apparent defect as in fact just a non-pathological ethnic trait. However, the patient's next remark about her husband's appearance shows she finds that the doctor has "misheard" her. She
tries to "correct" his interpretation by implying that her observations did not involve all or most Germans, as the doctor claims. The doctor ignores her rebutting remark, apparently in an attempt to prevent this potentially frightening topic from further being discussed. Staff tend to assume that patients who are nurses or midwives are already trained in the medical perspective on the proper "frame of mind" and behavior in labor. As a result, most staff, except Bartlett and several obstetricians, may simply sanction them for mentioning "complications," as if they "should know better." Apparently, most staff at City expect "exemplary behavior" from such patients in labor. For example, in the following case, an obstetrical nurse is sanctioned for mentioning her past experience with excessive bleeding in the delivery room.

Patient: "I saw the movie on home delivery in England. It scared me. One thing I used to dread in the delivery room is bleeding. People used to say there is no blood in the delivery room. I've seen sheets of blood."

Dr.: "What kind of talk is that?"

A private obstetrician supports these observations in his description of the "pressures to act like the exemplary mother-to-be" which his wife experienced when she assumed the role of patient to deliver her baby. This suggests that staff assume that a patient does not necessarily have to be formally socialized in the medical perspective to warrant expecting and enforcing "higher standards" of behavior—just be related to one who has been so trained. This doctor deliberately avoids
going into the delivery room to witness his wife's delivery to prevent this "pressure" from being even greater. Also, he suggests that even he would have difficulty sustaining the viewpoint prescribed by the medical perspective were he to act as an observing husband.

(Here he is discussing these issues with a couple in the labor room.)

"Did you deliver your own children, Dr. Sweeney?" Sydney (the patient's husband) changed the subject quickly.

"No," I said. "I've known obstetricians who have, but I wouldn't want to. Because I'm no longer a doctor then. I'm too emotionally involved to think the way I should. I don't take care of anybody in my family."

"I guess you watched your children being born, though," Sydney said.

"I was in the labor room but I didn't go into the delivery room." Bonnie (the patient) and Sydney looked surprised. "It's different when Sydney comes in with you, because he's not a doctor. Having a husband there who is a doctor puts an awful lot of pressure on the guy who's doing the delivery. And it wouldn't be fair to my wife, either. There was enough pressure on her already because she was Dr. Sweeney's wife in labor. She would really have had to act like the exemplary mother-to-be if I were present."35

In the following case, staff show how they may explicitly invoke her occupational status as a way of reminding her that the medical perspective should apply to her own delivery as well, and that they expect her to govern her own behavior accordingly.

Dr.: (as he enters the delivery room) "I understand you're a midwife. You've been through all this from the other end."

Patient: "It's different this way."

Intern (chastising): "That's what they all say."
Patient: "It's embarrassing!"

Intern: "It's all the same thing."

Note that the patient's reply ("It's different...") suggests she has heard his opening remarks as implying that because the patient is a midwife, she should experience her own delivery in the same way as she viewed others' deliveries as a practitioner. Thus, she is quick to correct this expectation that she will behave as a "colleague," implying she can not view it from the prescribed medical perspective. The intern then chastises her for disavowing that these expectations still apply to her as a patient. By so doing he suggests that they will hold the patient accountable for her behavior vis-a-vis the ideal patient in the medical perspective, regardless of any disclaimers on her part. When she protests that she finds being the patient embarrassing, she seems to be claiming that the lay perspective on labor and delivery is governing her behavior and experience, especially with regard to conventions of modesty which govern the public exposure of one's genitals. However, in reply, the intern returns to the theme introduced by the doctor at the outset ("It's all the same thing."), to persuade her not to attend the obvious sexual overtones of her position. Like the doctor, he proposes that the patient should regard a continuity between her occupational perspective and her patient experience, whereby normal lay relevances are to be suspended and treated as sanctionable if introduced into the delivery room.
As in the clinic setting, staff are concerned to prevent sexual overtones from arising and to manage them if they are introduced by the patient or younger staff member. To this end they employ draping, euphemistic terminology, and other techniques used in the clinic. Also, as in the clinic, one of the most common management methods involved ignoring sexual implications introduced by the patient. For example, in the following case the patient points out the sexual overtones of a doctor's question, after first showing that she has heard it as a "medical question" by answering it in a competent manner, i.e., as it was apparently intended by the speaker.

Dr.: "How are your legs?"

Patient: "My legs are ok, yes. But I would like to have them closer together. But I guess you can't do that! Ha! Ha!" (The doctor does not reply to this remark.)

Similar to the case of the midwife, this patient is pointing out how the medically prescribed position for delivery (and pelvic examination) affects her legs in a moral as well as medical manner. This reveals that from the lay view, many doctor's questions both here and in the clinic setting can be heard as double entendres. She seems to be mildly protesting how staff are forcing her to violate "leg discipline" wherein women in our culture are socialized to observe structures of modesty by keeping their legs together in public to conceal the genital area. However, by next treating this protest as intended in a joking manner ("But I guess you can't do that. Ha! Ha!") she shows she realizes she has spoken "out of place" as a
patient and that she has been socialized to some extent to accept the medical or technical necessity for this procedure. This stands as an apology for making the insulting implication that staff are gratuitously or for voyeuristic purposes exposing her genital area.

In his dramaturgical study of pelvic examinations in a private office, James Henslin found this same lay concern with the sexual overtones of the position they must assume for the examination and delivery.

**Thigh Behavior.**
American girls are given early and continued socialization in "limb discipline," being taught at a very early age to keep their legs close together while they are sitting or retrieving articles from the ground (but, see Suttles 1968: 67 for possible ethnic differences). They receive such cautions from their mothers as, "Keep your dress down," "Put your legs together," and "Nice girls don't let their panties show." Evidence of socialization into "acceptable" thigh behavior shows up in the vaginal examination while the women are positioned on the examination table and waiting for the doctor to arrive. They do not let their thighs fall outwards in a relaxed position, but try to hold their upper or midthighs together until the doctor arrives. They do this even in cases where it is very difficult for them to do so, such as when the patient is in her late months of pregnancy. Although the scene has been played such that desexualization is taking place, and although the patient is being depersonalized such that when the doctor returns, he primarily has a pelvic to deal with and not a person, at this point in the interaction sequence, the patient is still holding onto her sexuality and "personality" as demonstrated by her "proper" thigh behavior. Only later, when the doctor reenters the scene will she fully consent to the desexualized and depersonalized role and let her thighs fall outwards.36

Henslin implies that after the arrival of the doctor, all patients are invariably so well socialized in the medical perspective that they always consent to this violation of lay modesty without protest or resistance. However, this example
I have just described in the delivery room demonstrates how a patient does not necessarily see herself as thoroughly "desexualized and depersonalized," nor does she always consent without protesting it as a violation simply because the medical staff are present. In the clinic pelvic examinations I observed, many patients voiced protests and embarrassment even after the doctor began the examination, or otherwise pointed out the sexual overtones of the activity. In fact, it appeared to be a continual management task with many patients to have them keep their legs apart after the examination had begun, requiring repeated reminders to the patient to "let her legs fall apart."
Thus I found, unlike Henslin, that many patients tried to exercise "leg discipline" throughout their time in the stirrups. This implies that most were not as socialized in the medical perspective as Henslin assumes and continued to regard the pelvic as having obvious sexual overtones. The case of the protesting midwife in the delivery room suggests that, indeed, even when medical staff are themselves subjected to the same treatment as patients, they too are not able or willing to merely assume a "depersonalized and desexualized role."

In the description of the clinic area, I pointed out how the younger residents and interns, using a "technical approach" to patient treatment, were less circumspect about preventing sexual connotations from arising and guarding the patient's modesty. Also, I found the younger staff there were less skilled in exercising moral control over the patient in
this regard because they treated the patient as a full coparticipant in talk, providing in the "give and take" of conversation an opportunity for her to introduce the lay perspective on the pelvic examination as a sexual scene. In the delivery room, I found the same difference in management techniques, or lack of them. As in the clinic area, the younger staff themselves would even introduce these connotations. For example, in the following case a young intern tries to apologize for taking a long time in sewing up the episiotomy incision and assures her that no complications have taken place which would require such a lengthy sewing period.

(The patient's doctor has already left.)

Intern: "I'm taking so long because I'm doing a little plastic surgery. Ha! Ha!"

Patient: "Will I be more beautiful down there? Ha! Ha!"

Intern: "Best looking bottom in town."

Husband (who has been witnessing the delivery): "I'll buy that! Ha! Ha!"

Intern: "A little candid commentary. Remember that when he's looking at all those 20-year olds."

Patient (irritated): "You talk from experience."

Here the intern uses a humorous remark to apologize. The humor, however, derives from the sexual overtones of his sewing operation. The patient clearly hears his remark as having sexual connotations and shows this by joining in to treat it as a sexual event. The husband counters the intern's praise for his wife's genital area ("Best looking bottom in town.") by implying only he is privileged to make such a sexual appraisal
("I'll buy that."). The intern then mildly chastises his implied, though humorous, sanction by characterizing it as "candid commentary" and suggesting to the patient that her husband's praise may just be flattery because of his presumed appreciation of other women. The patient seems irritated at what she apparently hears as his implied accusation of her husband as being "unfaithful" in his attention to her. She counters his remark by sanctioning him wherein she accuses him of attending to the sexual attractiveness of his patients. Thus, by introducing the sexual connotations of his treatment, the intern provokes a disruption or confrontation where the husband implies that "it is none of his business" (suggesting overtones of jealousy) and an exchange of accusations of "promiscuous" prurient interest follows. Again, older, more experienced staff typically are more circumspect about such matters and appear to avoid acknowledging sexual overtones introduced by the patient and mentioning such implications themselves. In fact, one obstetrician pointed out to me how sensitive he was to the heightened sexual overtones when the husband is excluded from the prenatal examinations and delivery room. He voiced a concern to reduce this assumed jealousy by allowing the husband to oversee his wife's treatment in the delivery room. At the same time, he suggests some patients are aggressively seductive, giving husbands grounds for jealousy.

It's likely a lot of husbands are jealous of the doctor, although they don't express it to him explicitly. Once
a husband told me in a tone of levity with a barb in it, "You doctors! My wife is in love with you." Wives are threatening in another way and more so. No wonder husbands are jealous. Their wives keep coming to me, but the husband has no access and isn't told much of what goes on. So it's good for the husband's fidelity and feeling he's a part and has a little responsibility, if he's there, even if only to observe the delivery. Most doctors feel the pressure of jealousy.

I found the older doctors more aware of the "pressure of jealousy" while treating the patient in front of the husband in the delivery room in that they were particularly circumspect in talk and behavior to prevent disruptions and accusations due to jealousy than the younger doctors and interns, such as the one described above.

**Normalizing Troubles**

When "trouble" or "complications" in labor actually occur, staff generally cooperate to conceal it from the patient as much as possible. However, often its occurrence warrants treating the patient in some non-routine manner which may suggest to the patient that "something is wrong." For example, the appearance in the delivery room and use of forceps can be a sign of serious trouble to the patient, so staff work to reduce or eliminate this implication. One frequently used method involves treating the use of a non-routine procedure humorously. For example, in the following case a doctor does not warn the patient beforehand of the necessity of a forceps delivery, but instead humorously mentions it to the patient while she is actively pushing out the baby. Presumably she will be too preoccupied with following his instructions to push
to be able to voice alarm or protest.

Nurse: "Deep breath and have it out in two minutes. It's coming."

Dr.: "I see I have an adversary. I'll have to use forceps! Ha! Ha! I'm on your side. Keep it up! That's a girl."

However, the presence of the mirror which allows the patient to view her genital area while lying flat on her back may be seen by staff as potentially undermining their efforts to reduce the visibility of such non-routine procedures as forceps delivery and some routine ones like the episiotomy which produce a good deal of blood, suggesting some difficulty or complication may ensue. This staff's view is also shared by a private obstetrician who relates how he found it necessary to try to persuade the patient to shut her eyes to avoid (presumably) alarming her.

She (the patient) was quiet, frightened. She tried to bear down when I told her to, but the baby didn't move. The widest part of its head wasn't coming out.

"I'm going to put on the forceps to help the baby's head come out, Bonnie." I wondered whether the mirror was such a good idea after all. "Why don't you stop looking for a minute."

"It's okay," she whispered. "I want to see!"

... I pulled gently against the forceps handles. The head moved down, and I released. Then I pulled again, holding the head against the vagina, which was relaxed and stretching enormously, as it does.

"Bonnie," I said, "I'm going to cut the episiotomy, and it's not the prettiest thing in the world. Why don't you close your eyes a minute. There'll be some blood."

"I want to see," she said stubbornly.
The epidural (a local, spinal anesthesia) had made a local anesthetic unnecessary. I held the forceps with my left hand and when Dr. Richards handed me the scissors, I cut the episiotomy. A crimson spurt of blood ran down the drapes beneath Bonnie's buttocks," Bonnie gasped.

As with a lack of progress in labor, staff usually are circumspect in communicating "bad news" about complications to each other. Typically, they speak very quietly away from the delivery table or simply monitor each other's treatment of the patient to obviate talking about the difficulty. When they have to perform some non-routine or even fairly routine procedure in dealing with the trouble, they often account for it as in fact a routine or non-pathological event, i.e., normalize or routinize it. Sometimes they simply do not mention why they are performing the procedure or announce beforehand what they intend to do. If the patient demands an account, they may normalize or routinize the procedure, as I just described, or else vaguely and euphemistically describe the trouble while praising or exaggerating the efficacy of the procedure being employed to remedy it. These observations at City are supported by the experiences of a private obstetrician in New York who relates how he dealt with a patient whose baby is diagnosed in "trouble" in the labor room, and later after she is rushed to the delivery room.

The labor nurse checked with us more frequently now to see how things were progressing. Shortly before I expected we'd have caput, I asked Miss O'Brien (the labor nurse) to stay with Jean (the patient) and told Ed (the husband) to come with me. I wanted to get caps and masks and show him how to put his shoe covers on before he came into the delivery room.
When we came back the nurse motioned me aside. "Dr. Sweeney, the last time I took the fetal heart, it was 125."

"Check it after the next contraction," I said. Abnormal fetal or baby's heart beat is 140. A fetal heart of 125 isn't dangerous, and it may only signify a transient distress—from pressure on the cord, for example—which causes the rate to drop during each contraction. But during labor if anything changes from the norm, we all get a wary feeling.

The nurse listened after the next contraction and I stood at her side, reading her entry in the chart: 11:15 a.m.—fetal heart 115.

... "Get a blood pressure and pulse," I told the nurse.

The notations she made in the chart were normal. Blood pressure was 110/70 and pulse was 80.

Motioning Ed back, I examined Jean vaginally. The membranes were bulging into the vagina in front of the baby's head.

"Jean, I'm going to rupture your membranes now," I said. It won't hurt. There are no nerves there, and it will speed things up a little."

Actually, the main reason I was doing this was to check the amniotic fluid, or water surrounding the baby, for meconium stains. (a test to see if the baby's in distress; the test reveals no stains—J.E.F.)

... I had a stethoscope on Jean's abdomen, waiting as she finished another contraction. The baby's heart rate had dropped to 104 and that was close enough.

"Give her some oxygen," I told the nurse.

The nurse grabbed the portable oxygen tank in the corner next to the labor cot, pulled out the mask, and opened the valve. "We're going to give you some oxygen, Jean," I said. "I don't want you to fight it, just breathe normally."

I put the mask down over her face, and her hands came up, trying to get rid of the mask so she could talk. The nurse grabbed her hands and I said, "Jean, listen to me. This is just oxygen. We're having a little trouble with the baby's heart-beat and the more oxygen you breathe, the better it is for the baby." She stopped fighting but
her eyes were wide open with panic. How do you reassure a mother at that point? "We're trying to increase the baby's oxygenation and the pure oxygen you take will reach him through the placenta." I wondered if doctors would soon prove whether or not this oxygen is of any real value. "Now just breathe normally," I told her. I looked at the nurse: "Hit the buzzer." (a gloss for the emergency buzzer)

(They rush the patient to the delivery room.)
"Okay, Jean, I'm right here," I said, identifying myself behind the mask. I was drying as fast as I could and getting into my sterile gear.

As soon as she heard me, Jean reached for the oxygen mask covering her nose and mouth so she could talk.

"Grab her hands," I said.

The intern held her wrists and she started to shake and twist her head frantically.

"Jean, listen to me. You're going to be all right. We just have to get the baby out a little sooner than we thought." She stopped twisting her head and stared at me, frightened to death. "We don't have to strap your hands down if you'll keep them by your sides, do you understand? You can't move them around or you'll get in our way."39

Note that the nurse does not announce the drop in fetal heart-beat in front of the patient, but instead "motions the doctor aside." Next, the doctor reads the nurse's entry in the history chart rather than ask her in front of the patient for the heart beat rate and the mother's pulse and blood pressure. He routinizes his rupturing the membranes as done to "speed things up a little" to prevent her from seeing this as a sign of trouble. When the difficulty warrants employing obviously non-routine procedure (giving the oxygen), he puts the mask over her without telling her the reason, nor does he allow her an opportunity to demand a warrant for this procedure. When she seems to require an account, he euphemistically describes the
trouble ("We're having a little trouble with the baby's heart beat.") and exaggerates the efficacy of the procedure to remedy (the oxygen). Note that he waits until she has the mask held over her mouth before delivering the "bad news." Presumably this serves to prevent the patient from loudly expressing alarm and demanding more specific (and negative) details of the baby's condition, and forces her to listen to his euphemistic account. When they arrive in the delivery room, again the mask is used to enforce the patient's limited rights to speak and thereby prevent her from voicing alarm and demanding an account. By this time, the baby's heartbeat has fallen to a dangerously low level (92), but the doctor glosses its condition to an even greater extent than before ("We just have to get the baby out a little sooner than we thought.").

At City "staff" or "clinic" patients are delivered by residents who take turns every two months. When difficulties arise in the labor of a staff patient, the resident whose "month" it is usually deals with it. However, if he happens to be home or busy with another case, sometimes the teaching resident, Dr. Sands, comes from the clinic with his student doctors. Thus, a troublesome labor in the delivery room becomes a teaching session where Sands tries to deal with the emergency, account for it to the patient, and lecture the students on the medical facts of the case all at the same time. As I described in the clinic, Sands and other "technically oriented" residents do not schedule their lectures on a patient's case for before
or after the pelvic examination. Thus, they show their concern for the priority of the teaching function over "personal" care for the patient by lecturing about the patient in her presence. In the case of the pelvic examination, this leads to faux pas or frank descriptions of the patient's case which could alarm her. Likewise, in the labor and delivery rooms the concern for instructing the students about the particular patient's difficulties also results in facts being available for the patient to hear which could be heard as "bad news." This becomes particularly interesting in light of the efforts that Sands also makes, like other doctors and staff, to gloss and conceal the "trouble" which warrants her non-routine procedure. Thus, he frequently undermines his own efforts at controlling the visibility of "bad news" by his technically complete and frank lectures to the students while treating the patient. For example, on one occasion, he brought his students along when called to do an emergency fetal monitoring of a staff patient of Italian extraction in the delivery room, while the staff resident in charge of the delivery floor was still at home. This procedure involves attaching an electrode to the fetus in utero so its "vital signs" could be monitored on dials and scopes outside the delivery room as well as taking a fetal blood sample. In this case, the patient has had a lot of bleeding which warrants the non-routine procedure. The resident suspects a possible abruption or mislocated placenta which could result in a massive and fatal hemorrhage at any time.
Resident: "Having much pain, dear?"

Patient: "It hurts."

Resident: "Okay. That's why we're looking after you."

Patient: "Where's my doctor?"

Resident: "You're not going to be delivered yet. Dr. B. has asked me to look at your baby."

Patient: (whining and groaning) "Oh God, my back."

Resident to students: "She's had pain and lots of bleeding since morning. We've taken her blood sample and felt for the baby. She had blood in her urine. She's 38 years old. It's her first birth. We expect a very difficult delivery. 9 hours of labor now. I think the membrane are ruptured. I don't feel any. The chart says she's been laboring for 3 days. Can we say that labor has started? No! Objectively, we can tell if the cervix has started to dilate and there are pains across the stomach. So, she's been really labored.

Patient: "Don't press down!"

Resident: "This has to be done. Where does it hurt? A lot of insulation there, so it's hard to tell the fetal heart rate. Take the acid base from the fetal blood system."

Patient: "I'd like to go to the bathroom. I'd like to go to the bathroom."

Resident: "Okay. Go ahead, dear. Pass your water. This is not going to hurt much. This might hurt a little. Mrs., you understand me." (R. raises the delivery table) This is going to be a bumpy ride for a while. There's the head and no membrane. (facetiously) See the little boy!"

Patient: "Big or little boy?"

Resident: "Okay, dear, breathe in and out. Try not to move too much. (to the students) It's hard
to explain to this type of patient. Lower your bottom, dear. Lay still for a minute. We'll soon be finished. (Patient cries and moans) Sh! Try not to move dear, it's very important. Don't move! (to nurse) Give her a Ph test. If her Ph is okay, we'll go ahead with delivery. Don't move! You're doing very well. That's a good girl! (the patient has stopped exclaiming and complaining) (to nurse) Hasn't Dr. B. (the resident) scrubbed up yet? I thought this was an emergency. (patient groans) Don't move! Breathe in and out just a few minutes."

Patient: "I can't."

Resident: "You can! I have to take some blood from your hand. Hold still."

Patient: "Ouch! Oh God! Oh God! I can't! I can't!"

Resident: (to students) "She's had an enema. She has lots of gas. Where does it hurt?" (listens with the stethoscope for the fetal heartbeat)

Patient: "Don't! What are you doing?"

Resident: "We're listening for the baby. It's very important."

Patient: "It hurts all over! Don't!"

Resident: (to students) "Her abdomen is tender all over and she doesn't like me to touch her. Try to relax."

Patient: "I can't relax because you're pressing!"

Resident: "Take it easy! We're not pressing now. We're finding baby. When it's the first baby, they don't just jump out, just relax. You're in pain, so don't get all tired out. (R. watches for the patient's reaction as he introduces an instrument into her uterus.) Okay. We're doing this to get a complete picture of baby."

Patient: "Why isn't Dr. B. here?"

Resident: "Dr. B. doesn't do this kind of work. He phoned me. Sorry if I hurt your feelings."

Patient: "Stop pressing me."
Resident: "Give him a good spanking when he gets out for causing you pain."

Patient: "I hope it's a girl because boys cause a lot of trouble."

Resident: "You feel all those pains because the baby is starting to go down. Relax between pains. Pretend you're sleepy."

Patient: (groans) "All those hands!"

Resident: "It's only me. It's important to learn about your baby. Okay? One down (procedure), another one to go."

Patient: (relieved) "Thank you. Thank you very much."

Resident: "Ok dear, the worst is over. Another uncomfortable thing down there. (to students) Italian patients tend to be screamy. For Italians, there hasn't been a quiet birth recorded. (patient groans a lot) Okay, dear. It won't be long."

Patient: "I can't!"

Resident: "In a little while I'll give you an injection. It's too early."

Patient: "Why?"

Resident: "We'll find out about baby first. Then we'll take care of the pain."

Patient: "It hurts."

Resident: "You have to put up with it. This is labor. If you don't have pain, the baby won't come down." . . . (to students outside the delivery room) "It's highly cultural, this expression of emotion. It's interesting how the patient adjusts to this. A lot of her pain is psychogenic, since she could feel the pain when the blood was taken from her hand. It makes you wonder. All her pain should be in her stomach and she shouldn't have the presence of mind to feel her hand. This contrasts with natural childbirth. That's really interesting. This is where the woman goes without morphine. I think this is a most wonderful thing—to breathe her way through childbirth. It's a
question of mind control."

Dr. B. (walks in irritated) "This was just an excuse to get me out of bed at 6:00. No abruption, just broken membranes. She complains a lot!"

Resident: "I think it's her nationality."

Dr. B.: "She's not bleeding, but she's started labor. She's been complaining a lot during her pregnancy."

At the outset, Sands asks a prefatory question about the patient's pain in order to have the patient—herself—see what trouble warrants the monitoring. Sands already knows that the patient is experiencing normal labor pains, but tries to gloss the suspected trouble by telling her it is her "pain." ("That's why we are looking after you.") When the patient asks for her "own doctor" (the resident whose turn it is to deliver staff patients) Sands tries to persuade her that she may not warrantably demand or "need" him until and unless she is going to deliver. Then he tries to support his warrant to care for her by asserting that she should accept his care because it is delegated by "her doctor." Actually, the chief of the service had Sands fill in because the resident was still at home when the "emergency" arose. Presumably, to tell the patient that he is a temporary substitute would imply that the procedure is not routine. Despite his circumspection in providing warrant for the procedure, he undermines it when lecturing the students in front of the patient about her bleeding condition and the expected "very difficult delivery." When the patient protests the pressing on her stomach, Sands merely invokes a vague medical necessity for the procedure ("This has to be done.")
rather than suggest exactly why or what trouble warrants the discomfort. In facetiously describing the sex of the baby ("See the little boy."), Sands makes a faux pas in that staff typically do not mention or guess what the possible sex of the unborn may be because it may "raise the hopes" of the patient and risk disappointment or rejection when the predicted gender does not arrive. The patient's reaction ("Big or little boy?") shows how a patient may take such a reference to gender seriously even when obviously done humorously. When the patient refuses to cooperate and lie still, Sands makes a potentially insulting remark to the students about "this type of patient." His remarks to them and the nurse on the Ph test and the absence of the resident at the "emergency" stand as an easily overhead faux pas, despite Sands routine assurances to the patient that she was doing "very well." When the patient finally demands to know why the procedure is being done, he glosses the trouble by again simply asserting its medical necessity ("It's very important."). Next he tries to deflect blame for her discomfort from the procedure to the baby and the normal labor pains it assertedly is causing. In the process, he tries to normalize her pain ("When it's the first baby, they don't just jump out . . . .") and blames the baby for causing it rather than his pressing on her ("Give him a good spanking when he gets out. . . ."). He does this after already admitting to the students in front of her that "Her abdomen is tender all over and she doesn't like me to touch
her." He is trying to get her cooperation or at least acquiescence in spite of the pain the procedure is causing her. When the patient repeats her request for her own doctor, he tries to warrant his presence and conceal the emergency by claiming expertise that in fact is not uniquely his ("Dr. B. doesn't do this kind of work."). He apologizes for the substitution while implying it is nothing more serious than a matter of hurting her feelings. When her doctor finally appears, Sands suggests to him that most of her "complaining" about labor pain is physiologically unwarranted ("It's her nationality."). In his lecture to the students he shows how staff try to teach this organizationally prevalent view of "bad" or "screamy" or "complaining" patients as being the result of "psychogenic" tendencies of certain ethnic and personality types. This view provides the vocabulary of motives whereby the source of patient's complaints can be located in the patient rather than the treatment procedures. Debunking "screams," crying, and protests of discomfort as gratuitous "complaining" provides in this case a way of accounting for the trouble he is causing the patient that deflects the students' attention from his competence in administering the procedure. In any event, the main point I wish to make concerning this case is that it illustrates how, when "technically oriented" clinic staff use a labor "emergency" as a teaching occasion, the concern for teaching may undermine the routine attempts to conceal or reduce the visibility of an occurrence
which probably would be received as "bad news" were it known to the patient.

Similarly, when a biologically troublesome baby is delivered, staff generally make efforts to reduce or conceal the "bad news" from the patient while she is an immediate witness in the delivery room. In other words, they use various interactional devices to "separate" the mother from the troublesome event while it is available for her to directly observe. On the other hand, the husband will be given a more frank, but still qualified, version of the event later, outside the delivery room. At City, the two most common troubles observed were premature and Rh negative babies. In most cases, the trouble was expected by the mother, yet nevertheless staff tried to describe or diagnose the baby as not being in "trouble," when in fact it was. This glossing procedure was most evident in Rh negative cases where often the baby may appear observably healthy, without the usually expected yellow coloration indicating jaundice. The following are some typical birth announcements in these cases.

Dr.: "It's a little girl, mother! After all that! She's all right! She's all right!"

Patient: "Is she yellow?"

Dr.: "No! Marvelous! No enlarged liver or spleen!"

Patient: "What? Really?"

Dr.: "How long abo was it (the intrauterine blood transfusion?) 10 days ago. Well healed (the scar from the transfusion injection) Getting fancier all the time, Betty."

......
Patient: "It's happening!"

Nurse: "It's a little boy, dear! Not a very little boy, either.

Intern: "It's an amazing pink!"

Nurse (to another nurse loudly): "It's beautiful, isn't it?"

In these cases of no observable trouble, staff will sometimes even hold the baby up for the patient's inspection just after it has been completely expelled. However, when the news of the delivery was conveyed to the waiting father in these cases, the doctor usually gave a more pessimistic view of the baby's condition. For example, the doctor walks into the waiting room and the husband meets him at the entrance, anxious for news.

Husband: "How's the baby?"

Dr.: "We're giving it an exchange but it's pretty good. It's a girl. We feel optimistic but we can't guarantee anything, especially for the first 24 to 48 hours.

Husband: "How much did she weigh?"

Dr.: "9 grams."

Husband: "Good. Over the danger level of 7 to 8 grams. Was it yellow?"

Dr.: "The skin was okay, but after the first half hour it becomes yellow. (The Dr. did not mention this to the patient when he praised the baby's skin color in the delivery room.) The cord was all jaundiced."

Husband: "I guess I better stop standing around here. But I don't want to get in the way upstairs. Can I see her?"

Dr.: "She's in the delivery room for one hour, so you
go up later. It was crying when it first came out." (I was told that this was of little medical significance--J.E.F.)

Husband: "That's supposed to be a good sign, but maybe that's an old wives tale." (This is what staff called it--J.E.F.)

Dr.: "It was breathing all right and the skin wasn't too bad."

Husband: "No brain damage if it's breathing."

Dr.: "I went to the pediatrician and asked him what I should say. He said tell him he's optimistic."

Husband: "Anything else wrong? Any beauty marks from the transfusion you gave the kid?"

Dr.: "None appeared. That transfusion will help the red blood cell count. The baby has a good chance and born in fairly good shape."

Husband: "The hemoglobin (in the transfusion) helps, doesn't it?"

Dr.: "It helps the condition of the oxygen, yes."

Husband: "You gave it last week."

Dr.: (irritated) "It still helped a lot! You seem very knowledgeable about the problems."

Husband: "I'm interested in the complications. Thanks a lot. I'll go get a cup of coffee before I see her."

Dr.: "Congratulations. . ."(shakes the husband's hand and leaves).

The husband's first question on the baby's health shows that like his wife, he too was expecting a biologically troublesome baby. Ordinarily, the father's first question to the doctor will be about the sex of the child and then about the health of the patient and baby. Nevertheless, the doctor attends to his first utterance as the normal slot for this news by proffering the baby's sex. The doctor hedges his initial
fairly positive prognosis by qualifying it as not a certainty ("we can't guarantee anything. . . ."). However, the doctor still proceeds to compensate for this negative qualification and the remark about jaundice (which he never mentioned to the patient) by pointing out that the baby was crying. The father, however, who is a planner for the hospital, gives the medically sophisticated characterization of that as false reassurance or an "old wives tale." The doctor persists and counters these negative and presumptuous remarks (for a lay patient) by indicating that the baby was breathing and qualifying his earlier--negative--observations on the condition of the skin. Also, he invokes the vague prognosis of the pediatrician ("optimistic") although he had not in fact consulted him before talking to the father. The father still does not act reassured and instead makes some authoritative statements on the medical significance of the breathing and transfusion for the baby's prognosis. Finally, apparently irritated by the husband's presumptuousness and refusal to be reassured, the doctor "puts him in his place" by sarcastically remarking on his authoritative stance to his wife's case ("You seem very knowledgeable."). The principal point I wish to make from this case is that it illustrates how staff endeavor to conceal and gloss "bad news" in the delivery room while more frankly describing the baby's condition to the husband outside. However, even in informing the husband, the doctor still qualifies this "bad news" by pointing out the hopefully compensating features of the baby's condition.
If a relative refuses to be appropriately reassured, despite a qualified or hedged positive prognosis and diagnosis, doctors tend to treat this as a sanctionable matter.

Likewise, if the patient herself fails to appear reassured by the staff's praises of her baby's health and appearance, then staff may treat this response as sanctionable. For example, when a patient remarks on the baby's lack of crying and movement, the doctor seems to "mishear" or redefine her observation as a sanctionable display of maternal rejection and proceeds to normalize its lack of activity.

Patient: "She seems to lack spirit."

Dr.: "Going to keep her, eh? Some are slow starters."

Thus, in addition to glossing a biologically troublesome baby with outright praise and selectively reporting compensating "positive" signs to the patient and husband, staff also employ various (positive and negative) sanctions to persuade them to adopt and sustain the prescribed optimistic and happy outlook and thereby avoid possible disruptive behavior by an alarmed mother or father.

One method staff also use to emphasize to the mother in the delivery room the positive good health of the afflicted baby involves doing a dramatically performed examination of it wherein they proclaim loudly it's positive "signs" of health while neglecting to mention symptoms of its affliction. In most cases of expected trouble, a pediatrician stands by with weighing scales and resuscitator. It is usually his task to
perform this elaborate examination. For example, when the pediatrician reports the positive results of various tests, he not only loudly announces them but characterizes them as being very strong.

Pediatrician (very loudly as he holds the stethoscope to the baby's chest) "The fetal heart beat is 150! It is so hard it hurts my ears!"
(normal rate is 140)

As with news about complications or lack of progress in labor, staff usually try not to mention the baby's problem in the mother's presence, except in hushed tones off to the side of the delivery room. However, as in these other attempts to control information available to the patient, the younger staff members typically commit more faux pas in their communications to and in front of the patient. For example, in the case of a Rh negative baby who has already been praised as healthy, an intern audibly describes the pathological condition to the doctor.

Intern to Dr.: "No doubt we have an involved baby."

Patient (alarmed): "Is she all right?"

Dr.: "Yes. We'll give it an exchange but there's no hurry. We'll do it in the next half hour."

Patient: "I am so glad she's all right."

Dr.: "Good for you! We're going to have a real good baby for you!"

Patient: "I can't get over how pink she was. I thought she would be all yellow."

The patient overhears this negative diagnosis and, alarmed, she inquires again as to the baby's health. In response, the
doctor tries to "repair" the intern's mistake by repeating his earlier positive diagnosis. Although he informs her of the need for a non-routine blood transfusion, he qualifies this potentially "bad news" by implying it is not an emergency and therefore there is no pressing, serious problem. The doctor positively sanctions her acceptance of this news as reassuring ("Good for you") by praising her and strongly promising a positive outcome of their treatment procedures. ("We're going to have a real good baby for you!"). Note that staff do not correct her apparent belief that the patient is not jaundiced because the skin was not yellow. In fact, they never explicitly diagnosed the baby as not jaundiced but merely let the patient draw this conclusion from the normal pink skin color when the baby was first expelled.

This information control was more difficult and, consequently, the interactional problems more severe when a baby was born visibly "troubled," as was the case with many undersized premature infants and those Rh negative babies who were discernably yellow from jaundice. In these cases the doctor just announces the sex of the baby without praise of any kind and does not hold it up for her examination. Instead, he quickly hands it to the pediatrician who quietly examines the baby with his back toward the mother so she cannot see it. The doctor usually does not bring up the topic of the baby's health and tries to engage the patient in conversation on other, less "risky" topics, such as whether the baby's sex
was the desired or expected one or how quickly and smoothly her labor had proceeded (even when it had not). Meanwhile, the pediatrician is quickly and quietly weighing, diagnosing, and treating the distressed infant without announcing any signs of health, positive or negative. Eventually, the patient, who has expected trouble, usually inquires in an alarmed fashion about the health of the baby. Then, either the doctor or pediatrician tell her the baby's condition and prognosis in a highly qualified manner. If it is fairly negative, they usually describe its problem in very vague and general terms with the usual qualification that "it is too soon to tell anything for sure." Likewise, if it is fairly positive, they still append this same hedge to a vague, general diagnosis and prognosis. Again, the visibly healthy Rh negative baby may be equally distressed but because of its appearance the staff may more easily conceal and gloss the "bad news" while emphasizing the "positive" symptoms of health. A private obstetrician in New York lends support to my observations at City in his description of how he and a pediatrician dealt with a patient and her husband in the case of an undersized premature baby. Here the patient is delivered of a "tiny premature male infant," but before the doctor could make the announcement of its sex, the patient develops severe bleeding and faints. The doctor works to stop the bleeding while the pediatrician examines and revives the baby. When the patient regains consciousness and the bleeding is stopped, the pediatrician brings the baby over
"(Where is) the baby?"

Dr. Rogan (the pediatrician) was just coming over with their little boy all but hidden in swaddling clothes. He touched the baby to Marianne's breast and arm. "You have a boy," he said, "and I want to get him right down to the premature nursery."

"He's so tiny," she whispered.

Marianne and Dan (the husband) stared. All they could see of their baby was his face, with bulging eyes. Marianne looked past Dan's shoulder at me. Her eyes widened at all the blood on my gown. Then she looked at Dr. Rogan.

"Please tell me if our baby's going to be all right."

"I think he'll be fine," Dr. Rogan replied. "We'll know a lot more later on."

... They took Marianne downstairs at 1 a.m. Dan and I went with her. He was gradually believing she was out of danger. Then I took him to the preemy nursery, because he had hardly had a chance to see his son. I explained that Dr. Rogan had wanted to get their baby into a warm incubator as quickly as possible: after months in a hot uterus, any newborn infant is cold in the delivery room.

The pediatrics resident told us Dr. Rogan had been there until a few minutes before. Dan appeared shocked as he looked at his naked baby through the window of the nursery.

"He's so tiny," Dan said, "so thin."

... Finally Dan asked me the question I'd been expecting. "Is he going to be all right, Dr. Sweeney?"

"It's too early to be sure, Dan. You can't just look at a preemy baby and prognosticate. He must be doing pretty well or Dr. Rogan wouldn't have left him. They'll know more tomorrow. The first twenty-four hours are the most important."

"He looks so fragile and helpless. There should be some way I could give some strength—" Dan's voice broke and he stopped. "How much does he weigh?"

At birth he had weighed 2,200 grams, which is 4 pounds and 7 ounces, but I told Dan he would lose some weight at first. All babies do.
Note that the pediatrician had wrapped the baby before showing him to the parents so its tiny body was concealed for the most part. In this case, also, the doctor had not held the naked, newborn baby up for the mother's observation. The pediatrician gives a general positive prognosis while hedging with the usual qualifier, "We'll know a lot more later on." When the doctor takes the husband to the "preemy" nursery, he tries to normalize the quick removal of his son to the incubator ("... any newborn infant is cold in the delivery room...."). Actually, babies routinely are kept in the delivery room for ten minutes or longer for the patient to hold and admire. The husband is shocked by complete exposure of the baby's undersized body, which suggests the efficacy of swaddling clothes to manage the "bad news" while in the delivery room. This provokes the husband to reinquire about the baby's prognosis. However, the doctor gives a more non-committal reply than did the pediatrician in the delivery room. In fact, he undermines the pediatrician's positive prognosis by claiming that a brief examination of a "preemy" does not provide medical grounds to prognosticate. Nevertheless, he tries to qualify this negative reply by claiming the absence of the pediatrician is indicative of a positive prognosis. Finally, he anticipates the baby's weight loss and tries to normalize it.

At City I found that exceptions to these information control practices generally were made in cases involving patients who were nurses or midwives by occupation. Staff
apparently assumed that they were knowledgeable of all the possible symptoms of complications of "troublesome" infants. Accordingly, their diagnoses were made with greater specificity and in technical terms with less attempt to conceal or downplay the "bad news." On the other hand, these patients were more apt to cooperate in preventing and reducing interactional problems by not pressing for news of the baby's condition while still in the delivery room. For example, the following case involves a midwife who has had past difficulties with her newborn babies and here delivers a premature, obviously jaundiced Rh negative baby.

Dr.: "He's out! A little boy! Is that what you wanted?"
Patient: "I don't care as long as he's healthy."
Dr.: "The baby's yours." (as he hands it to the pediatrician)
(Pediatrician examines the baby with his back turned toward the patient so she can not see the yellow, undersized baby. After examining it he announces:) "The heart beat is better. It was irregular for the first minutes. Not bad now." (sends baby to intensive care without showing it to the mother.)

Dr.: "The baby had jaundice like you had. It can cross over into the brain after a certain age. It's not good. Anemic and has heart trouble but enough blood will clear the pigments out. Five pounds, eleven ounces."
Patient: "Pretty good."
Dr.: "I knew it wasn't a 'four pounder.'"
Nurse: "Thirty weeks--okay. Very good."
Dr.: "The bigger they are, the sooner the liver starts to work."

The doctor avoids any reference to the baby's health in the
birth announcement. Instead, he tries to get the mother to focus on the desirability of the sex of the child. However, in reply, the patient points out her primary concern for its health. Nevertheless, then and throughout her stay in the delivery room, she refrains from directly asking the doctor about its health or prognosis (none is offered). On the other hand, atypically (for troublesome cases) the doctor and pediatrician introduce the baby's health as a topic, pointing out its "positive" signs as well as giving specific, technical descriptions of the baby's condition. He tries to "redeem" its less than normal weight by creating a contrast conception of a "four pounder" against which it can be flatteringly compared. Although this patient is told specific technical information of its condition, she is never shown it nor does the pediatrician discuss the fetal heart beat until it has improved. Also, the doctor tries to qualify his negative diagnosis of jaundice, anemia, and heart trouble by pointing out the efficacy of a transfusion in repairing one (though minor) trouble, the baby's yellow coloration, which itself is of little medical concern except as a symptom of liver dysfunction. Thus, even where a patient is fully informed about her baby's troubles, the staff are circumspect about not pointing out to the patient possibly transitory troubles, such as the initial low heartbeat rate, and in qualifying any diagnosis of more permanent difficulties.

At City, the most difficult and severe interactional
problems arose with the delivery of a biologically troublesome infant which was unexpected by the doctor or patient. Again, the difficulties in managing this "bad news" varied with the visibility of the trouble, the majority being visibly troubled. When a baby was pallid and not breathing, for example, the doctor usually just announced the baby's sex and quickly took it over to the side of the room and kept his body between it and the mother while trying to revive it. The mother is not shown the baby until and unless it is fully revived and its appearance improved. A pediatrician is not present because trouble was not anticipated, and must be summoned. Until he arrives, the doctor alone must manage the patient's alarmed inquiries about its health while also trying to concentrate on reviving it. He may simply not respond to the patient's questions or else just describe the treatment he is administering to it. Similarly, the delivery room staff collaborate with him in not treating her alarmed inquiries as a question, but instead respond to them with repeated expressions of "Relax, Mrs. ____ . The doctor is taking care of the baby."

In other words, the patient is to be kept completely uninformed until the doctor decides on some sort of diagnosis and prognosis and the baby's condition can be improved. If the baby cannot be adequately revived, then it is quickly removed to intensive care for further treatment without giving the patient a chance to see it. Only when the baby has been taken away does the doctor tell the patient the "bad news" in vague, general terms
and with the usual qualification such as "It's too soon to tell" or "We'll know a lot more later on." In support of these observations at City, I would like to relate a private obstetrician's attempts to deal with a patient when her baby is unexpectedly born without healthy color and not breathing. The baby has been quickly delivered by forceps when its heart-beat rate had dropped to a dangerous level, although the patient was not informed specifically of its problem.

... I turned the baby, working as quickly as possible. The right or top shoulder came out first. Then I lifted and eased out the left one and the rest of the narrower, wet body followed without difficulty. "It's a boy," I said automatically, but I didn't like the looks of this just-born infant. Healthy babies are not pink, their're blue when they first emerge ... . But this baby was pallid, almost white, because his heart had been pumping blood at a reduced rate. And he was too limp. Even before a baby starts breathing, it's got a certain amount of muscle tone. If you pick up the leg, it doesn't just flop down again. The baby may even move its fingers. But this infant wasn't well ... . "Watch Mrs. Simpson," I told Dr. Orsini (the resident). I carried the motionless baby a few fast steps to a table along the wall.

... Suddenly I hear Jean's (the mother) expectant voice. "Can I see my baby?"

The silence in answer to her question caused her to cry out sharply, "My baby!"

"I've got him, honey," I said.

Anguish pierced her voice as this made her realize something was terribly wrong. "What's the matter?"

Ed (the husband) answered steadily, "Dr. Sweeney's taking care of our baby, sweetheart."

"What do you mean, taking care of him?" A note of hysteria shattered her words. "What does that mean?"

"We're giving him some oxygen, Jean," I said.
"Mrs. Simpson, lie back. Please." It was Dr. Orsini. Then Ed's voice covered his: "You'll hurt yourself, sweetheart. You've got to listen to Dr. Orsini."

(The pediatrician arrives and takes charge of reviving the baby.)

Jean stared at me as I came to the table. "Please tell me how our baby is."

I can't lie to a mother at this point. Her baby wasn't breathing. "He's not very good right now, Jean, but it's too soon to tell anything."

"Oh my God," she whispered and turned her face away, crying helplessly. "Oh God, let him be all right, please just let him be all right."

The fundus nurse said, "Her uterus is contracted, Doctor."

A minute later the placenta started to deliver, and Jean begged, "Please tell me how my baby is."

"We will," I said. "Just as soon as we know."

(Later the baby starts to breathe and cry.)
"Oh my God, I hear him, I can hear him," Jean cried.

Dr. Rogan (the pediatrician) brought their son over and put him on Jean's stomach. "He's a good little boy," he said. 41

The doctor only announces its sex and immediately starts trying to revive it. He ignores her request to see her baby and does not tell her why, other than the fact that he has it. Also, he ignores her direct question about its health ("What's the matter?"). The husband collaborates with the doctor in concealing the problem by providing an evasive answer to her question wherein he merely assures her that the baby is being taken care of by the doctor. Likewise, when the doctor replies to her inquiry, "What does that mean?," obviously intended to
ascertain the trouble warranting the doctor's care, he merely answers it literally by telling her he is caring for the baby with oxygen. Then the resident and husband try to calm and quiet the patient while the doctor works on the baby. When the pediatrician takes over care of the baby, the doctor finally gives her a negative diagnosis in highly qualified, vague terms. Apparently finding his diagnosis less than informative, the patient later repeats her question about the baby's health, but the doctor backs off from his vague diagnosis, claiming the staff just did not know the baby's condition at the present time, when in fact they know it has not breathed yet. As I found at City, the intent is to avoid giving the patient any specific information on the baby's condition, so long as it is negative and the baby is still in the delivery room.

2. Ibid., p. 521.

3. A report in a consumers' newsletter, Moneysworth, IV (New York: May 27, 1974) supports my finding that the decision to induce a patient may be based on considerations of work scheduling:

   BIRTH OF A NATION: The Royal College of Midwives states that London doctors are inducing labor in pregnant women in order to permit more and more British babies to be born between 9 A.M. and 5 P.M. The process is an attempt to cope with night staff shortages in British hospitals. At the rate things are going, women will have to be increasingly selective about the time they choose to deliver; If your doctor's out to lunch, chances are you'll be out of luck.


8. Ibid.

9. These patients are seen as candidates for c-section usually on the basis of a previous delivery wherein they had a lengthy and painful labor and delivery. From staff's point of view, a repetition of this sort of vaginal birth
represents a risk to the newborn child, who may suffer from the effects of an overly long labor, and to their own competence and work schedules. Doctors may attribute the previous lengthy labor and delivery to these patients' "lack" of ability to control their emotions, particularly in expressing pain, which they feel seriously interferes with their ability to follow staff's instructions to relax and push effectively in delivering their babies. Thus, doctors may feel that they must take into account this ability (or lack of it) in deciding on the type of delivery of subsequent babies: surgical or vaginal.


12. Phenomenologically, it is not the exact act of crying or complaining that nurses react to but the symbolic meanings attached to them by medical ideology. Specifically, medical texts and lectures describe for staff the effects that the dilatation of the cervix has on the nerves in the pelvic region of the body: the greater the expansion of the cervix, the more likely it is that the patient will experience (and therefore express) pain, particularly during the stage of labor called "transition" when the cervix is fully expanded and the baby is beginning to be expelled from the uterus.


17. Ibid.

18. "... I want some part in this." may also be interpreted as the doctor's attempt at humor. In other words, one interpersonal management technique that staff employ may involve trying to gain the patient's cooperation through


20. Ibid.


22. Kitzinger, Giving Birth:, p. 43.

23. International Childbirth Education Association, "Birth Reports."

24. Ibid.

25. Again, this plea illustrates staff's use of humor to gain the cooperation of patients by attracting the patients' attention to the doctor's commands and to distract her, at least temporarily, from the stress of labor, which may be preventing her from complying.


27. Ibid.


29. International Childbirth Education Association, "Birth Reports."

30. Ibid.

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Sweeney, Woman's Doctor:, p. 175.


39. Ibid., pp. 55-59.

40. Ibid., pp. 233-234.

41. Ibid., pp. 60-63.
CHAPTER VI

CONCLUSION

This chapter will attempt to pull together some important aspects of the dissertation and give the reader a final view of what it has attempted, and what it claims to have achieved. Hence, I will first briefly describe the analytical and methodological framework I chose to use in this study, and its advantages over other, more commonly used, approaches in enabling me to obtain the findings reported in this dissertation. Then, I will conclude this final chapter with a discussion of some of the substantive findings reported in preceding chapters.

Framework

The primary goal of this dissertation has been to show how seemingly "technical" or "natural" events in the hospital (e.g., "prenatal care," "labor," and "childbirth") are shaped to a significant extent by the staff members' work routines--especially those involving patient management--which they develop to cope with the practical structure (e.g., demand characteristics) of their everyday work.

To try to achieve this goal I chose the analytical approach found in the works of ethnomethodologists Roy Turner and David Sudnow. Hence, I sought to analyze actual on-going
interaction between hospital staff members and patients in terms of its constitutive, concrete organizational procedures and methods. I tried to point out how for staff members in their everyday occupational routines patient management methods constitute a significant part of the procedural definition of obstetrics.

To produce data which could be usefully analyzed with this perspective, I followed Turner's conception of an ethnographic study of occupational routines as a general guide for the methodology of this study. Hence, I acted as a non-participant observer in order to provide as data a continuous record of social phenomena, i.e., a method that tries to describe and account for commonplace features of an actor's on-going organizational life.

The resultant findings, reported in preceding chapters, deal with the organization of work routines mainly in terms of patient management techniques, different approaches or medical philosophies to the implementation of ideological ideals in management routines, and the work exigencies or demand characteristics shaping the techniques in use. These findings suggest how for some patients, particularly, these techniques cause "problems," such as embarrassment and "lack of adequate attention" to their individual medical and social "needs." On the other hand, by acting as less than "model" patients, these same patients often provoke staff members to use these techniques.
The discovery of these management techniques and the organizational events and pressures which occasioned their development and use, I contend, was very much dependent on my adoption of an ethnographic research strategy—non-participant observation—and a theoretical approach to "technical" and "natural" events in the hospital in terms of their constitutive procedural bases in everyday occupational routines (which I sum up by the phrase "doing obstetrics"). The more commonly used structural survey-interview approach, on the other hand, has been concerned to find the social or cultural components of "biological" and "technical" events, such as prenatal care and childbirth, as such components were made up of abstract, general norms, beliefs, and attitudes (summed up by terms like "doctor and patient roles"). Methodologically, this theoretical approach translates into the quantitative measurement by surveys and interviews of the extent to which doctors and patients subscribe to various kinds of attitudes, beliefs, norms and roles, which they are assumed to follow as "programs" for action when actually interacting with one another and producing such "biological" events as labor and childbirth. Then, "problems" patients experience at the hands of doctors and the "difficulties" different types of patients cause staff members are explained in terms of the participants' subscription to kinds of social roles and the degree to which these normative elements are "complementary" or "conflicting." My contention is that by focusing almost exclusively on abstract normative elements in
the actors' perspectives, this research strategy overlooks the situated, practical features of the organizational setting that competent members must take into account in their everyday encounters. Furthermore, the inadequacy of this standard strategy may result in demonstrably spurious results by leading the researcher to look only outside the actual organizational features of interaction for explanations of "problems" or "inadequacies" in the administration of medical "treatment." This contention is supported in Chapter IV, particularly, where I compared the two research strategies as applied to "problems" in labor and childbirth that a patient may experience, e. g., "lengthy labor" and "caesarian section." As the reader will recall, in that Chapter I justified my choice of an ethnographic approach—-and rejection of survey methodology—on the grounds that it provides the data base—details of everyday interaction—necessary for an adequate analysis of the significant role of patient management routines in shaping "natural" and "technical" events in labor and delivery, e. g., "length of labor," "complications of delivery," "caesarian section," etc. In sum, what I am arguing for is the necessity of studying the "natural social order" of a hospital (or any occupational setting) in any argument or characterization dealing with events occurring within it.

Substantive Findings

In my chapters on the intake area of the Clinic I described staff members' patient management routines and their
view of themselves as having a mandate to instruct and lay the whole routine of prenatal care on patients, regardless of their situations and views. Many patients' "reactions" to staff's "treatment" here and in other areas of the hospital can index their character as "troublesome" for staff. In other words, I found systematic attempts to coerce patients to "shape up" so that in the always-orientated-to final stages—labor and delivery—they will (hopefully) be "good patients." Also, we saw staff members protecting standardized routines—e.g., requests for a female doctor—get treated as organizationally disruptive. Also, I showed how the social worker in the Clinic is occupationally trained, as part of the medical "team," to look ahead to the baby's "fate" after birth—issues of father's employment, adoption, etc. Here, and with physicians, too, I showed how the medical shades off into concerns with "model middle-class family arrangements," and staff seem to take for granted their mandate to enforce these.

More specifically, when patients who have had their babies in a non-medical setting (or voice intention to have them in non-medical settings) come to the Clinic for services over which medical personnel have a monopoly—registration of birth, diagnosis of pregnancy, and general physical check-ups—staff members use these occasions to check on their compliance with prenatal and post-natal medical care routines. If they are found to be "negligent" parents or reluctant to accept prenatal care and delivery in the hospital, staff members use
threats of legal sanction and moral persuasion to "teach" them the value of medical care, which is claimed to be necessary to meet their "responsibilities" to the unborn or newborn child. In the intake and cubicle areas moral persuasion may involve attempts to scare or shock the patient with anecdotes of where, e.g., a non-medical delivery or "neglect" of prescribed prenatal regimens resulted in severe complications in delivery or even natal death. Alternatively, staff members may try to persuade the patient to cooperate on the grounds of the "medical facts" of her case, including some vague or implied threat of trouble for a patient of her "medical type"—e.g., "You're seventeen and this is your first baby. You should be where you can see a doctor every month."

If patients will not be persuaded to cooperate, they may be given an ultimatum by staff whereby they accept the prescribed medical regimen or be turned away from the Clinic without the service they sought, e.g., a diagnosis of whether they were pregnant, or a general prenatal physical check-up.

In dealing with patients who threaten standardized routines—e.g., requests for a female doctor—staff may try to protect them (the routines) by routinizing and normalizing the offending routines. If patients do not respond in the desired manner to this technique, staff then often ridicule and discredit their objections as superfluous or unwarranted by virtue of their lack of good moral character. Also, they treat the recalcitrant patient's motives as problematic and hold her
publicly accountable for them. Finally, if the patient will not be shamed or censured into foregoing her objections, staff may issue an "ultimatum" similar to that used with patients who will not cooperate fully with medical regimens in prenatal or post-natal care.

In order to try to exert moral control over the patient's preparation for parenthood, including her financial, occupational, and marital affairs, staff may turn the intake interview and the medical interview in the cubicle area into didactic sessions. In these cases the social worker or doctor may ask presumptuous "leading questions" and rhetorical questions to encourage the patient to see deficiencies in her "life style" and then they proffer advice as to what she "could" (to be heard by her as should) do about the "pressing" problem(s). Staff members then "follow up" these sessions with regular reminders to the patient of her "problems" and chastisements if she does not follow their proffered advice—e. g., "What" Still no job?"

In my chapter on the cubicle area I showed how work exigencies such as scheduling and providing a visibly competent performance result in only the occasional implementation of the ideals of the medical ideology in regard to patient management techniques (including the "necessity" to "teach" patients, treat their "individual problems," and give proprietous care); an approach to patient "care" and the teaching of students I termed the "technical approach" as opposed to the academically-located "patient as person" medical philosophy or approach which supports the more consistent implementation of ideological
ideals in everyday work routines. I described the organizational problems and work orientations of medical students and young residents because they did most of the work in the area. Also, I showed how they received "pep-talks" containing ideal ideological components on the "patient as person" approach that downgraded the "technical approach," which was commonly followed in clinic work routines. However, I showed how students had to come to terms with the demand characteristics of the situation (e.g., work scheduling and visible competence) once they get to the cubicles where they actually work with patients.

More specifically, the use of a "technical approach" to patient management by clinic staff resulted to some extent from their concern to limit the work day and provide for regular work breaks—e.g., "Everybody here is in here and out to coffee as fast as they can." Another demand characteristic making the implementation of ideals of patient management problematic is the necessity to complete the medical history and the general physical examination in less than a half an hour in order to provide a visibly competent performance and cope with a heavy work load. In other words, most staff members typically do not prove patients' responses in the interview for accuracy or try to "establish rapport" or give advice, due to the saliency in their work orientation of "not taking too much time" with any one patient. This pressure results in an emphasis even in pedagogical "pep-talks" on
performing only a "reasonable" general and pelvic examination to establish "reasonable" health. Also, mitigating against the actual implementation of the "patient as person" approach, while paying "lip-service" to it in lectures, was the fact that many younger staff members treat the clinic as primarily a teaching and learning setting where the patient is regarded as a "technical object," i.e., as a "pregnant girl" who exhibits a set of symptoms. Many staff members, then, are not particularly circumspect in preventing sexual and moral connotations from arising and not especially concerned to seek out and deal with the patient's "social problems," e.g., they may ask the patient at the beginning of the pelvic examination to "spread your legs," or try to persuade the patient not to press "family problems" on them. Also, as a result, they may not exercise "team discipline" and circumspection in discussing a patient's case in front of her, including voicing differences of opinion as to how she is to be treated. Patients, in these cases, may become alarmed or insulted by what they are able to discern about their case from the doctors' "technical talk."

Finally, a "technical approach" to patient management may also result from staff members' lack of experience with "handling" patients or lack of familiarity with medical literature supporting the consistent implementation of "patient as person" ideals. I found in my study that older, more experienced doctors differed from "raw recruit" students and
younger residents not so much in technical skills and knowledge, but in skills in exercising moral control over the patient, e.g., younger staff members were not as adept at tightly managing interaction so that patients were not treated as equal co-participants in conversations. Typically, there was more "give and take" in these encounters, providing more opportunities for patients to introduce sexual and moral connotations. Furthermore, younger staff members were found to provoke more frequently moral reactions from patients by their "artless," "crude," questions and comments, which invited moral implications—e.g., Student: "Have you had intercourse regularly?" Patient: "Yeah. I'm married. Ha! Ha!" Likewise, when trying to employ small talk as a management technique to "distract" the patient from the sexual and painful implications of the pelvic examination, younger staff members were found to be less circumspect and artful in the selection of topics and initiating conversations.

In Chapter V I documented the intransigence of labor and delivery for organizational programming, as well as the patient management routines developed to cope with the naturally difficult features of these processes in terms of the demand characteristics of scheduling them as work and providing a visibly competent performance while "aiding" these processes.

Specifically, I found that staff members used medical procedures—pitocin, anesthesia, forceps, caesarian section, etc.,—to control "length of labor" and manage organizationally
troublesome patients. These methods of physical intervention were often explicitly justified to the patient as medically warranted as being "for her own good." Staff members also tried to "fit" the process of labor into the supervising doctor's work and leisure schedule by summoning him only when the last stage of labor had begun. In order to do so they relied on normal labor typifications of the average length of labor and behavioral displays by patients.

Besides using methods of physical intervention, staff members tried to coerce cooperation by "guiding" the patient to get maximum effect of each labor contraction. These interactional management techniques included instructions to the patient on how to "correctly" push, as well as "pressuring" her to follow these instructions and exert maximum effort in pushing out the baby. Also, the staff worked as a team to persuade the patient to adopt and display the "right attitude," i. e., "a relaxed, happy mental approach," so she does not "lose control" under the "stress" of labor. Conversely, when staff members desired to delay the delivery to allow (e. g.) the supervising physician time to arrive and "take part" in it, they may instruct and exhort the patient to "hold" the baby and not to push it out, even though she may have a strong desire to do so. Like physical methods, these interactional techniques were explicitly justified on medical grounds as being warranted by the patient's (or baby's) particular physiological problems in labor and delivery.
In "pressuring" a patient to push harder and more effectively, staff often would loudly command her to do so—e.g., "Let's have this baby!" When the patient is viewed as being "negligent" in pushing, staff may cajole ("Come on, you!") name-call ("You're a lazy thing!") or try to frighten the patient by describing possible "complications" that might occur if she fails to cooperate with their instructions ("If you could listen to the fetal heart beat, you would find it's loud because there's pressure on the baby's head... please push to bring its head down!")

Staff members develop similar interactional management techniques to quiet "noisy" and "complaining" patients—thereby rendering them "good patients" who will (hopefully) be able to respond "correctly" to their efforts to "pressure" her to be a "good pusher" during the final stage of labor: commands to "stop making noise" and "get it all under control," verbal and physical sanctions (e.g., stifling the patient when she makes "noise"), promises of a short labor, reassurances of having made "good progress" in labor and that there are no medical troubles warranting her "loss of control."

As in the Clinic, younger doctors and staff members differed from more experienced personnel mainly in their skill in exercising moral control over patients so as to produce organizationally "good patients" in labor and delivery.

Finally, to ensure a happy, relaxed attitude on the part of the patient when physiological troubles occur in labor or delivery or with the newborn infant, and to avoid possible
disruption, staff develop methods of reducing the visibility and significance of this "bad news" for the patient. These techniques of information control involve attempts to normalize and routinize such potentially disruptive events, as well as simply trying to conceal symptoms and signs of trouble from the patient.
FOOTNOTES


2. Ibid.
BIBLIOGRAPHY


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