

Self-Initiated Problem Presentation in Prenatal Checkups: Its Placement and Construction

Aug Nishizaka

*Department of Sociology
Meiji Gakuin University, Tokyo, Japan*

Unlike primary care acute visits, which are occasioned by a matter of concern to the patient, regular prenatal checkups provide no structural positions for presenting problems that they wish to discuss. I find that there does nevertheless seem to be a systematic sequential position (namely, where an incipient activity is in progress) at which pregnant women can and do raise their concerns. I examine the defensive and evidence-sensitive nature of the construction of the problem presentations initiated at this position. I thereby demonstrate the mutual dependence between the position and construction of problem presentations. The position and construction of presentations are consequential to the way in which health-care professionals respond to them; they may engender a cycle where the pregnant woman (re)attempts to legitimize her original problem presentation and the health-care professional (re)attempts to confirm her or his no-problem response. In conclusion, I discuss some implications of the present study for the study of medical interaction in particular and the study of human interaction in general.

In this article I explore some aspects of interactions in regular prenatal checkups during which pregnant women present their problems. I then go on to examine the possible consequences of these practices for the subsequent trajectory of the interaction. There have been several studies of problem presentation by patients in primary care acute visits in general medicine (see Heritage & Maynard, 2006, among others). The present study focuses on problem presentation in regular prenatal checkups.

A major difference between primary care acute visits and regular prenatal checkups lies in the fact that, whereas the very reason for a patient to visit a doctor in the former *is* the patient's (acute) problem or concern, the reason for a pregnant woman's visit to an obstetrician or a midwife in the latter is not any particular concern that she may have; she is there simply to have a regular checkup. This difference is consequential for the ways in which pregnant women raise matters that concern them. Since no specific position for presenting their concerns is structurally provided in terms of the overall structure of the medical visit, pregnant women who have problems that they wish to discuss may need to take the initiative; they may need to find a way to insert their problem presentations into the ongoing development of the interaction. In what follows, I describe some

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Correspondence should be sent to Aug Nishizaka, Department of Sociology, Meiji Gakuin University, Minato-Ku, Tokyo 108-8636, Japan. E-mail: augnish@soc.meijigakuin.ac.jp

practices that pregnant women employ to initiate problem presentations in regular prenatal checkups.

The research literature on medical interaction only rarely addresses how patients manage to raise matters that concern them in interactions with medical professionals, other than in response to being asked by a doctor about their problems. Stivers and Heritage's (2001) report of patients' practices for "breaking the mold" is probably the most significant exception. They show how a patient who visits a doctor for a routine checkup in a primary care context exploits her answers in response to the doctor's questions as opportunities whereby to expand her answers to raise concerns, even by breaking out of the constraints imposed by the questions. Indeed, this is one of the practices that I observe in my data. However, I focus on a more prominent practice by which pregnant women interject into the ongoing activity to create an unsolicited opportunity to raise their concerns—namely, exploiting a point at which an incipient distinct activity is in progress.

The problem presentation initiated at this position appears to have a specific construction, or design. In the present study, I will explore orderly features of this sequential position and the construction of problem presentations at this position. In what follows, I will describe my data and methods and outline the features of a sequential position for the self-initiation (i.e., unsolicited initiation) of problem presentations in regular prenatal checkups. I will also contrast this with positions for the initiation of problem presentations in primary care visits occasioned by the patients' concerns. Then I will explore the orderliness of these features, through an overview of various positions for the (self- and other-) initiation of problem presentations in prenatal checkups, and explicate specific features of the design of problem presentations at that sequential position. Turning to the responses to these problem presentations by health-care professionals, which are shown to be constrained by the position and the design of the problem presentations, I suggest that the ways in which health-care professionals respond may engender a cycle of (re)attempts by pregnant women to justify their concerns and (re)attempts by health-care professionals to confirm their no-problem responses. In the concluding section, I will discuss some consequences of my analysis.

DATA AND METHODS

The data analyzed in this study are audio and video recordings of 42 prenatal checkups conducted at five obstetrical hospitals and clinics, four obstetrical divisions of general hospitals, three midwife houses,¹ and one pregnant woman's home. They were collected in large and middle-sized cities in the eastern and western areas in Japan in 2002 through 2008. Thirty-three pregnant women and about 30 health-care professionals, i.e., obstetricians, midwives, and nurses, agreed to participate in the research with informed written consent, including permission for the transcribed data to be published. In the reproductions of data extracts in this article, all proper names are changed to pseudonyms.

In Japan, many pregnant women visit an obstetrical doctor or a midwife for periodic checkups, once their pregnancy is determined. Usually, at the end of each visit, the doctor or midwife tells the pregnant woman when she should have her next checkup, with a subsequent appointment being made at the reception desk or later by phone. Generally, pregnant women are recommended to

¹Midwives are entitled to practice independently in Japan. I call the places for their practices "midwife houses." Midwife houses are different from clinics and hospitals in regard to both institutional structure and appearance.

come in for a checkup every 4 weeks before the 30th week of their pregnancy, and every 1 or 2 or weeks after the 30th week until the prospective delivery.

My method in the present study is conversation analysis (see, e.g., Heritage, 1984; Schegloff, 2007). My focus is on the practices that the participants employ to produce the orderly features of their activities, rather than empirical uniformities or patterns observable in their behavior. Sacks characterized the aim of his research as follows: “What we ought to seek to build is an apparatus which will provide for how it is that any activities, which members do in such a way as to be recognizable as such to members, are done, and are done recognizably” (Sacks, 1972, p. 332; see also Sacks, 1992). The number of the cases I consider in what follows is small, but they are not idiosyncratic to those three or four women, because they are still cases of publicly intelligible and recognizable distinct activities, i.e., problem presentations. In this study, I aim to describe some procedures that will provide for the orderly production of recognizable problem presentations (see also Garfinkel, 1967, 2002; Garfinkel & Sacks, 1970; Garfinkel & Wieder, 1992; Sacks, Schegloff, & Jefferson, 1974, among others).

CONTRAST BETWEEN TWO SETTINGS

In this section, I remind the reader that going to the doctor’s office for a first, or one-off, visit, usually means that the doctor will at some point give you an explicit occasion to report what is wrong or what the doctor can do for you. This will give a background against which the distinct positions of pregnant women’s problem presentations in regular prenatal checkups can be thrown into relief.

The Primary Care Visit Occasioned by the Patients’ Concerns

Extract 1 is an excerpt from the beginning of a patient’s first visit to a gynecologist.² This is a typical primary care visit, occasioned by the patient’s concern. The problem presented by the patient is occasional pain that she experiences in the area of her left ovary. The doctor (DOC) first calls the patient (line 01), and the patient (PAT) responds to the call (line 02).

Extract 1 [Fibroid II: 1]³

01 DOC: <shinohara kayo> sa::: ɾⁿ
 PN PN Ms.

“Ms. Kayo Shinohara.”

02 PAT: ɽhu:::i
 yes

“Yes.”

²In what follows, I also examine two segments of interaction from another set of data, i.e., audio and video recordings of about 30 acute and routine visits by nonpregnant women to a gynecological clinic, which were collected as part of the same research project in 2002 through 2004.

³All the extracts cited in this article are composed of three tiers: At each numbered line, there is first a romanized version of the original Japanese. Below this is a phrase-by-phrase gloss, and finally, on the third tier, a rough English translation. The first tier of transcript utilizes a transcription system developed by Gail Jefferson (see Jefferson, 2004b, for the most recent version). Furthermore, the following abbreviations are used in the phrase-by-phrase glosses in the second tier: IR for Interrogative, JD for Judgmental, MIM for Mimetic, P for Particle, PL for Polite, and PN for Proper name.

- 03 DOC: *hai doozo:=ohairi kudasa:i*
yes please come-in would-you
“Please come in.”
- 04 (0.8)
- 05 PAT: Γ Γ (>onegai<)>shimaa::s'. Γ
thank-you
“Thank you.”
- 06 DOC: \perp \perp *hai ohayoo gozai* \perp °mas °
yes good-morning PL
“Good morning.”
- 07 (.)
- 08 KIN KN \perp ki ((The patient hits the stool.))
- 09 PAT: \perp °a su- Γ £suimasen£.°
oh sorry
“Oh, sorry.”
- 10 DOC: \perp IMA KYOO wa (0.6) nanka
currently today P any
- 11 *shinpaina koto ari masu (°ka°)*
worried-about thing exist JD IR
**“Currently, today ((do you have)) anything ((you are))
worried about?”**
- 12 (0.4)
- 13 PAT: *iya: ee:::to::g* Γ :: Γ ::
no uhm
“No, uhm”
- 14 DOC: \perp \perp \perp
yeah
“Mm hm”
- 15 PAT: (.) *hi* (.) *dari no*
left P
- 16 DOC: \perp
yeah
“Mm hm”
- 17 PAT: *ransoo atari*
ovary around
- 18 DOC: \perp \perp
uh huh
“Uh huh”
- 19 PAT: *atari: (.) ga tama ni (.) itamu yo* Γ o \perp na
around P occasionally hurt like
“it seems like around the left ovary ((I)) occasionally have pain.”

The patient’s problem presentation is solicited by the doctor’s inquiry (lines 10–11); the sequential position for this problem presentation is characterizable in the following way. In this primary care context, the reason for the patient’s visit is supposed to be revealed in the course of the visit. This

TABLE 1
The Trajectory of a Primary Care Opening Section

1. Doctor:	Summons
2. Patient:	Answer
3. (Doctor: (Patient:	Invitation to enter the consultation room, etc.) Entrance, etc.)
3. Doctor:	Initiation of Problem Presentation
4. Patient:	Completion of Problem Presentation

supposition appears to constrain the trajectory of the entire visit. Though the very first attempt at access to medical care has been made by the patient, the actual first encounter is initiated by the doctor, who calls or summons patients (see line 01 of Extract 1). As Schegloff (1968, 2002) observes, a summoner is expected to initiate an activity after she or he receives a response from the summoonee. If the reason for the visit is a problem, problem presentation is precisely the activity that is expected to be done on that encounter. The interactional trajectory that the opening section of a first visit to primary care doctor is expected to go through is represented in Table 1 (see Robinson, 2006, and Robinson & Heritage, 2006 on the opening sequence of primary care acute visits).

After the completion of a summons–answer sequence, the doctor, who initiated the summons–answer sequence, is expected to initiate a problem–presentation sequence, as the doctor does in lines 10–11 of Extract 1 by asking “Currently, today ((do you have)) anything ((you are)) worried about?”

Thus, the sequential position for problem presentations by patients in this type of primary care context is structurally provided in two ways. First, it is structurally provided locally by sequence organization (Schegloff, 2007); a slot is assigned to it by a doctor’s inquiry, which serves as the initiation of the sequence type *inquiry-answer*. Second, if the patient’s reason for visiting is a medical problem, revealing the problem is normatively expected to be the first business to be undertaken by both participants following the opening section of the visit. The position for problem presentations by patients in this primary care context is structurally provided by the overall structure of the single visit as well as the local sequencing structure; the position for problem presentation is the position for the first business of the entire visit, expectedly following the opening sequence.

The Regular Visit

In contrast, when a pregnant woman visits a doctor or midwife for a regular prenatal checkup, the reason for the visit is transparent to the health-care professional from the outset, that is, to have a regular prenatal checkup; problems that the pregnant woman may have are *not* the reason for the visit. Therefore, problem presentations by pregnant women during regular checkups may not have any position specifically structurally provided for them by the *overall* structure of the visit.

Extract 2 is an excerpt from a pregnant woman’s regular checkup at the obstetrics and gynecology division at a general hospital, and is one of those on which this study will focus. As is usual in regular prenatal checkups, one of the health-care professionals, here a midwife, is recording the measurement of the abdominal girth and the fundal height (the distance between the pubic bone and the top of the uterus; see Figure 1). The pregnant woman (PWM) produces her utterance in lines 01–02 precisely at the time that the midwife (MDW), measuring the abdominal girth, starts to read the tape measure which she is now holding on the woman’s abdomen (see Figure 2).

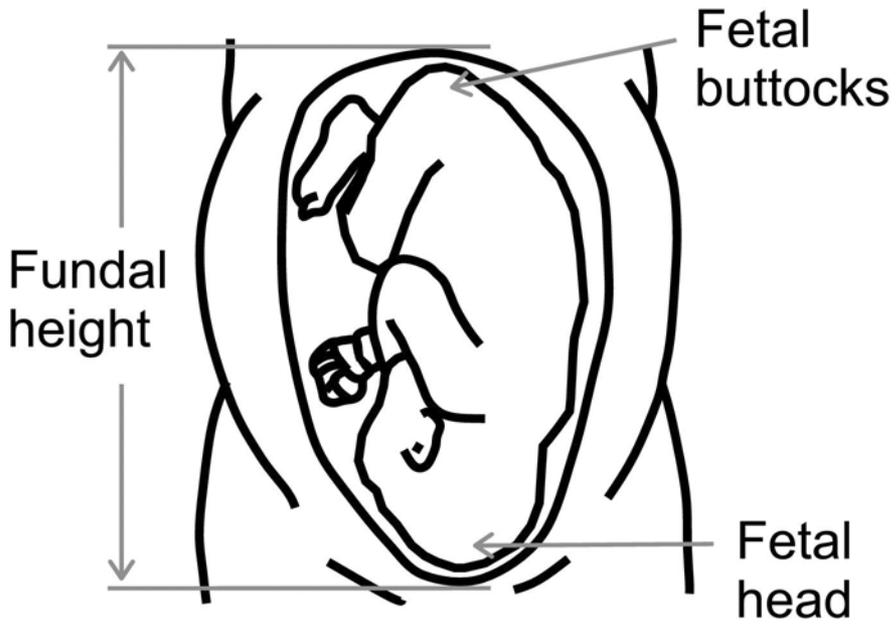


FIGURE 1 Fetal presentation.



FIGURE 2 The midwife starts to read the tape measure immediately before line 01 of Extract 2.

Extract 2 [SU II]

- 01 PWM: >nan'ka< minna kara: onaka chissai 'tte
kind-of everyone from stomach small that
- 02 *i(h)wa(h)re(h)n(hh) de(h)s(h) kedo(h).*
am-told JD though
“(I) am told by everyone that ((my)) stomach is small.”
- 03 (MDW: *nm*)
yeah
“Mm hm”
- 04 (4.2)
- 05 MDW: *demo akachan no ookisa betsu ni*
but baby P size not-particularly
- 06 *futsuu nande(h).*
normal because
“But the baby’s size is normal [not particularly abnormal], so.”
- 07 (.)
- 08 PWM: *daijo'bu de ʔs u ka : (h) ? ʔ*
alright JD IR
“(Is it) alright?”
- 09 MDW: *┌da(h)i(h)jo(h)bu(h)┐ des'(h).*
alright JD
“(It is) alright.”
- 10 PWM: *n*
yeah
“Yeah.”

The pregnant woman’s utterance in line 01–02 can be heard as possibly expressing a concern. She builds this possible problem presentation through formulating her abdomen as *noticeably* small, thus displaying an orientation to the possibility that this noticeable smallness is an indication of abnormality. Indeed, in response to this utterance, the midwife exhibits her understanding that the pregnant woman has presented a problem in the following ways.

First, the midwife introduces her utterance in line 05 with a marker of disagreement (*demo* [“but”]), thereby constructing her incipient utterance as a disagreement to the pregnant woman’s preceding utterance. Second, the midwife formulates the (unborn) baby’s condition as normal (*futsuu*) in her disagreement with the pregnant woman. The midwife thus takes the pregnant woman to have implied something opposite to the normal development of the baby. Furthermore, after the midwife’s utterance, the pregnant woman requests confirmation, reformulating the baby’s condition as nonproblematic (*daijoobu* [“all right”] in line 08), and the midwife provides confirmation, by repeating the same term used by the pregnant woman (*daijoobu*), in line 09.

Taken together, both participants display a mutual orientation to the pregnant woman’s first utterance as a problem presentation—despite the fact that it is produced at a position that is not structurally provided for a problem presentation in terms of either the overall structure of the visit or the local sequencing structure.

Certainly, as we will see in the next section, doctors or midwives often inquire, during a visit, whether there is anything that concerns the pregnant woman. Such inquiries provide pregnant

women with a *locally* structurally provided position or slot for problem presentation. However, one should note, this position is not one structurally provided, in terms of the *overall* structure of the visit, for revealing the reason for the visit. Indeed, pregnant women often provide a no-problem answer to such questions.

The Second Reason for a Primary Visit

On the other hand, patients who visit a primary care doctor because of their concerns may also initiate their problem presentations without having them solicited by the doctor. One of the loci in which this recurrently occurs is the position immediately following the completion of considering the first concern, i.e., the first reason for the visit. The following is an excerpt from a patient's (not pregnant) second visit to a gynecologist; she came for a gynecological checkup (a general checkup for women, including various tests for uterine cancer, uterine fibroids, hormonal imbalance, etc.) on this first visit. Now she has come to receive test results and the doctor is telling her that no problems were found (Extract 3).

Extract 3 [Infertility II: 2]

- 01 DOC: ...*insee de shinpai nashi.*
negative so worry no
“...negative, so there is no worry.”
- 02 PAT: *hai arigatoo gozai masu=*
yes thankyou JD-PL
“OK, thank you very much.”
- 03 PAT: \uparrow .hh
04 DOC: \downarrow *ichi nen kan hoshoo.*
one year period guarantee
“One-year guarantee.”
- 05 PAT: *i \uparrow chi(h)ne(h)n ho(h)sho(h) \downarrow*
one year guarantee
“One-year guarantee.”
- 06 DOC: \downarrow ehhh hhhh \downarrow
07 PAT: \downarrow *arigato go gozai ma:s£<.= \uparrow .hh*
thankyou JD-PL
- 08 DOC: \downarrow .ehhh \downarrow hai.
yes.
“Yes.”
- 09 PAT: *ee:to watashi ne: (.) hitori me- futari me ga*
well I P first second P
10 *nakanaka:: (1.4) <atawara nai'n desu kedo:>*
for-a-long-time given not JD though
“Well, I have not been given a first- a second ((child))
for a long time.”
- 11 (0.8)
- 12 DOC: \uparrow a soo.
ah so
“((You)) have not.”

- 13 PAT: L^o_{n:n}^o
 yeah
 “**Yeah.**”
- 14 PAT: *ha:i*
 yes
 “**Yes.**”
- 15 DOC: *hitori me wa? nan'sai?*
 first P how-old
 “**How old ((is)) the first ((child))?**”

After telling the patient that all the results are good, the doctor sums up in line 04, by jokingly giving the patient a “one-year guarantee,” thereby bringing this sequence dealing with the first reason for the visit to a close (see Schegloff & Sacks, 1973). The patient registers the joke by repeating it with laughter in line 05, and then expresses her gratitude in line 07, thus displaying her understanding that a general evaluation of all the test results has been provided. However, after the doctor’s acknowledgment of the patient’s gratitude in line 08, the patient initiates a problem presentation, revealing her concern about infertility in lines 09–10.

The point to be made here is as follows. Certainly, the default (normatively expected) number of reasons for a visit to a health-care professional seems to be just one. Therefore, unless particularly indicated otherwise, the completion of the sequence dealing with the first reason is also expected to constitute the beginning of the completion of the entire visit. However, the sequential position following the completion of the consideration of the first reason affords a structurally provided position in which to raise a second reason that the patient may have. After the sequence involving the first reason is completed and before the closing of the visit as such is yet accomplished, a space can be structurally provided for presenting a second reason, if need be (see Schegloff & Sacks, 1973 for their discussion on the sequential position following the completion of the first topical talk in telephone conversation). Insofar as there is a structurally provided space for a second reason for visiting, the sequential position where the patient in Extract 3 initiates a problem presentation is *that* position—structurally provided for an additional problem presentation in terms of the overall structure of the primary care visit.

In sum, in the primary care context where visits are occasioned by the patients’ concerns, positions for problem presentations are structurally provided by the overall structure of the visit, whether or not locally provided as slots following the doctor’s solicitation. In contrast, in regular prenatal checkups, no *particular* positions for problem presentations are structurally provided by the *overall* structure of the visit—though some positions may be locally provided by the health-care professional’s solicitations (i.e., inquiries about whether the pregnant woman is concerned about anything).

In the remainder of this article, I explore orderly features of a particular sequential position in regular prenatal checkups for pregnant women’s self-initiated problem presentations, and then explicate the practices by which they (the women) construct problem presentations in orderly ways at this position. I also discuss some consequences of this relation to the subsequent trajectory of the interaction. Before doing this, I will overview various positions for problem presentations in regular prenatal checkups in order to offer some sense of the orderliness of these positions.

SEQUENTIAL PLACEMENTS FOR PROBLEM PRESENTATION IN REGULAR PRENATAL CHECKUPS

In regular prenatal checkups, there are several structural locations that both health-care professionals and pregnant women can use to initiate the women's problem presentations.

Overview of Structural Positions for Pregnant Women's Problem Presentations

These structural niches for the initiation of problem presentations are describable as follows.

Health-Care Professionals Other-Initiate (i.e., Solicit With an Inquiry) Pregnant Women's Problem Presentation

At the beginning of an encounter (Extract 4).

Extract 4 [FK III: Rough translation (Original in Japanese)]

((Immediately after a midwife enters the room where the pregnant woman has been waiting, to offer counseling, the midwife asks a general question.))

- 01 MDW: → Ok. Do you have any concerns today?
02 PWM: Not particularly, today.

(The pregnant woman offers a no-problem answer here, but it is easy to see that the midwife's inquiry is providing a position for problem presentation.)

At a closing section of an encounter (Extract 5).

Extract 5 [SZ I: 1: Rough translation (Original in Japanese)]

((After the doctor and the pregnant woman agreed on the date of her next visit, the doctor suggests that she, the woman, may come earlier than the date.))

- 01 DOC: You may come earlier if you have any concerns. (.)
02 → Any other questions, //do you have?
03 PWM: Well, . . .

(In response to the doctor's inquiry in line 02, the pregnant woman asks the doctor whether she can take a flight in the 33rd week of her pregnancy.)

At a juncture between distinct activities or utterance sequences within an encounter (Extract 6).

Extract 6 [FW IV: Rough translation (Original in Japanese)]

((The midwife is suggesting that, considering the current week of pregnancy, the woman should learn how to massage her birth canal later during this visit.))

- 01 MDW: Let's do it, //yeah.
02 PWM: Yes.
03 (0.3)
04 MDW: → Other- uh any other concerns?
05 PWM: .hhhh well recently I feel pain around my anus.

In the history-taking phase (Extract 7).

Extract 7 [FW I: Rough translation (Original in Japanese)]

- 01 MDW: → Abdominal tension?
 02 PWM: Some.

(When held at a midwife house, designated as FW, checkups are begun with history taking.)

Occasioned by the preceding exchanges of utterances (Extract 8).

Extract 8 [FW V: Rough translation (Original in Japanese)]

((The midwife has been instructing the woman in the 36th week of pregnancy how to exercise in order to adjust her body for the prospective delivery. During the instruction, she (the midwife) happens to mention stiff shoulders.))

- 01 MDW: Stretch your arms like this, and the exercise
 02 against stiff shoulders should be //done to gain
 03 good ((blood)) circulation, //and
 04 PWM: Done
 05 PWM: Yes.
 06 MDW: → Yeah. (.) How about stiff shoulders?
 07 PWM: Stiff shoulders ((are)) terrible.

Occasioned by the ongoing activity (Extract 9).

Extract 9 [HM I: Rough translation (Original in Japanese)]

((Two midwives visit a pregnant woman's home. One of them massages the woman's left leg.))

- 01 MDW: → Don't you have cramps in your left leg? All right?
 02 PWM: Right- (.) This morning, //I felt some pain.
 03 MDW: Uh huh.
 04 MDW: Oh, really.

(The midwife's inquiry is hearably occasioned by the massage in progress. The midwife's inquiry is also hearable as a preliminary to the subsequent trajectory of the massage, in that if the possible problem, i.e., cramps, is confirmed, the subsequent massage ought to be conducted more carefully in one way or another.)

*Pregnant Women Self-Initiate (i.e. Without Being Solicited by the Health-Care Professional's Inquiry) Their Problem Presentation**At a closing section of an encounter (Extract 10).*

Extract 10 [JH I: Rough translation (Original in Japanese)]

((The doctor is suggesting that the woman may come in earlier than the appointed date for the next checkup if she has any concerns.))

- 01 DOC: You could come without an appointment,
 02 PWM: Yes.
 03 DOC: remember //this, please. //Okay.
 04 PWM: All right.

- 05 PWM: → Well, my child often comes up onto my belly when
 06 → we are in the bed at night, uh

(The pregnant woman goes on to express her concern more explicitly by asking if there would be no adverse effects on the fetus.)

At a juncture between distinct activities or utterance sequences within an encounter (Extract 11).

Extract 11 [FW VI: Rough translation (Original in Japanese)]

((The midwife inquires about the woman's bowel movements while her massaging legs.))

- 01 MDW: How are your bowel movements?
 02 PWM: Oh well
 03 (.)
 04 MDW: yeah
 05 PWM: Nor//mally, //no //constipation.
 06 MDW: And-
 07 MDW: that's good.
 08 MDW: No constipation.
 09 MDW: No.
 10 (7.4)
 11 PWM: → And I feel terrible pain at the pubis

By expanding their answer to the health-care professional's inquiry (Extract 12; see Stivers & Heritage, 2001).

Extract 12 [FW I: Rough translation (Original in Japanese)]

- 01 MDW: Do you have a lower back pain?
 02 PWM: As for the lower back, //(I) do not feel any pain,
 03 MDW: Is all right.
 04 PWM: → but the groin
 05 (.)
 06 MDW: Uh //huh.
 07 PWM: here is

(The pregnant woman takes advantage of the slot for her answer to the midwife's inquiry to mention a separate, though related, problem [i.e., pain at the groin] from the queried problem [i.e., backache].)

Occasioned by the preceding exchanges of utterances (Extract 13).

Extract 13 [FW IV: Rough translation (Original in Japanese)]

((The midwife palpates the woman's abdomen.))

- 01 MDW: ((The baby)) is now at a very good position. //Yeah.
 02 PWM: → .h Well but the other day Dr. Tomiyama said ((the
 03 → baby)) had not come down sufficiently

Occasioned by the ongoing activity (Extract 14).

Extract 14 [FM VI: Rough translation (Original in Japanese)]

((The midwife is going to palpate the woman's abdomen. In line 06, the woman tells the midwife that, because she is wearing thermal pants under her skirt, she will need to pull her skirt down "from the top", together with the pants. In line 07 the midwife registers what the pregnant woman has said, after looking at the pants.))

- 01 MDW: Now, ((your)) stomach, //let ((me)) examine.
 02 PRW: Yes.
 03 MDW: Would ((you)) pull ((your)) skirt //up. Yeah
 04 PRW: There we go.
 05 (.)
 06 PRW: Anyway, from the top.
 07 MDW: Oh I see.
 08 (.)
 09 PRW: → Yes. (0.4) Though not cracked when ((I delivered
 10 → my)) older child, ((my)) stomach is a little bit
 11 → cracked, ... so ((I)) think ((the baby)) is quite
 12 → big.

(In lines 9–12 the pregnant woman expresses her concern about the size of the expected baby when she is revealing her abdomen for palpating. The problem presentation in Extract 2 is initiated at the same class of position, i.e., "occasioned by the ongoing activity.")

Two points about this overview: First, there is a wide diversity of sequential positions for the initiation of problem presentations, whether other- or self-initiation, and the number of instances in my data corpus for each sequential position—in particular the number of instances in which any problem is presented actually following the initiation at each place—is quite small, around five or so. This diversity reflects the fact that no position for problem presentation is specifically structurally provided by the overall structure of regular prenatal checkups. Second, there is nevertheless a common theme, and inspection reveals systematic positioning for problem presentation, thus affording a systematic description. The positions for problem presentation in Extracts 2 and 14 are located where *incipient activities* (reading the tape measure and palpating the woman's abdomen, respectively) are in progress.

Incipient Activities

The visit is made up, among other things, of a series of activities, usually initiated by the health-care professional, and in which the pregnant woman is an active or passive partner (having her blood pressure taken, having her abdomen measured, and so on). It is at this point that I find that the women in Extracts 2 and 14 present their problem, and the problem is meant to be heard as related to the incipient activity going on. The women's concerns about the size of the fetuses and/or their uteruses are hearably raised to be dealt with in the subsequent course of the activity. The self-initiation of problem presentations at these positions is expected to be consequential to the subsequent trajectory of the activity in progress (in the very same way as the problem presentation in Extract 9, which is cited as an instance of other-initiated problem presentation occasioned by the ongoing activity).

These positions may be systematic positions in which to raise various concerns to be dealt with in the subsequent course of the ongoing activity. Indeed, two pregnant women in my data remind health-care professionals, who are beginning ultrasound examinations, that their fetuses were in breech presentation on their previous visits. In the following case, the doctor, after listening to the fetal heart tone with a Doppler heart monitor, assesses it positively in line 01. During a substantial silence in line 03, the doctor is preparing for an ultrasound examination (putting jelly on the transducer, etc.). The pregnant woman's utterance in lines 04–05 is produced immediately after the doctor begins to turn the monitor screen slightly towards the pregnant woman (Extract 15).

Extract 15 [TE II]

- 01 DOC: *chōdo ii* Γ *toko desu* Γ *ne:*
just good place JD P
“The speed is very good.”
- 02 PWM: L *hai* L *hai*
yes oh yes
“Yes.” “Oh yes.”
- 03 (14.6)
- 04 PWM: \rightarrow *sen getsu chotto atama ga: ue ni ki te ta*
last month a-little head P up P came
- 05 \rightarrow *mita* Γ *datta n' desu kedo:* Γ
like was JD though
“((I)) was told that the head was up last month.”
- 06 DOC: L *soo desu-* *aa soo sa* L *kasa n' natte ta*
so JD oh so upside-down P became
- 07 *n' desu ka ne: soo* Γ *ima ni- a- shita* Γ *e:=*
JD IR P well now down P
- 08 PWM: L *kon getsu wa:-* L *a-*
this month P
“This month-”
- 09 DOC: *=ki te masu kara n* Γ *e*
come JD because P
“Right- Oh ((it)) was upside-down. Well now ((the head)) is down.”
- 10 PWM: L *yoka(h)ttah de(h)su hh*
oh good JD
“That's good.”

Immediately following the woman's report of the fetal presentation at the previous visit, the doctor tells her that the presentation is now cephalic, i.e., normal (see Figure 1 for the normal presentation of a fetus), while looking at the ultrasound monitor. Hence, the expression of her possible concern, just at the moment when the doctor is observably beginning the ultrasound examination, is treated as requesting the doctor to check the current fetal presentation precisely during the current incipient examination.

In Extract 2, on the other hand, the midwife responds to the woman's problem presentation by mentioning “the *baby's* size” (i.e., rather than the size of the abdomen). Immediately before she

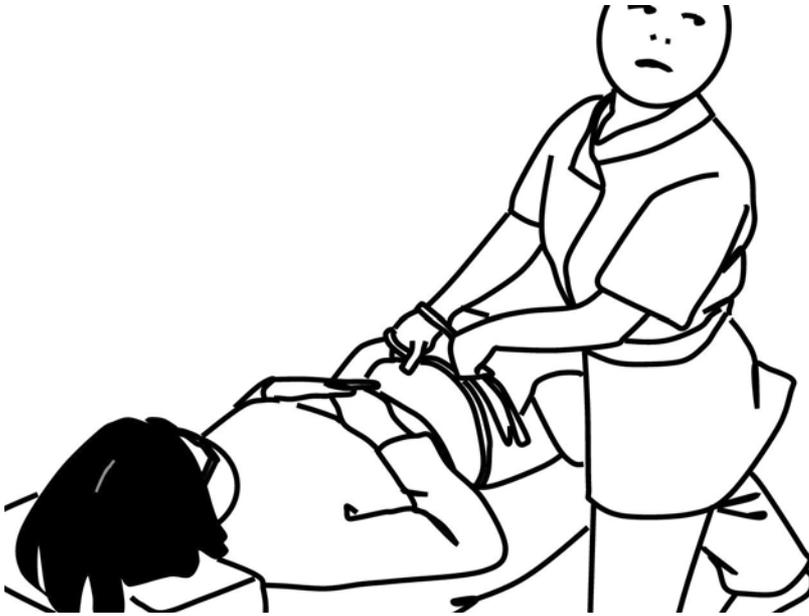


FIGURE 3 The midwife examines possible evidence before responding to the pregnant woman's problem presentation (Extract 2, line 04).

responds, the midwife turns her upper body and looks at the computer monitor behind her during the 4.2-second-long silence in line 04 (Figure 3). Through her body torque (Schegloff, 1998), the midwife is *doing looking* at the computer monitor, so that "the baby's size" can be heard to be found on the monitor, even though what is there may not be available to the pregnant woman. In other words, in Extract 2, the midwife's response to the problem presentation is not related to the incipient activity in progress (i.e., reading the tape measure); it even intersects the expected trajectory of the ongoing activity, in that the midwife redistributes her orientation from the operational field for the ongoing activity (i.e., the woman's abdomen) to the computer monitor behind her. However, the practice that the woman in Extract 2 employs to present her concern is the same as that in Extract 15. She fits her problem presentation into the position in which the presented problem can be expected to be addressed in the subsequent course of the activity in progress.

DESIGN OF SELF-INITIATED PROBLEM PRESENTATION IN THE COURSE OF INCIPIENT ACTIVITY

Another Case for the Phenomenon

Interestingly, a different woman at a different institution self-initiates the presentation of a very similar problem in a very similar sequential position, with a similar design or construction to that in

Extract 2. Extract 16 is an excerpt from a pregnant woman's visit to a doctor. The doctor in the excerpt is starting an ultrasound examination. After turning off the room light in order to improve the visibility of the image on the ultrasound monitor, the doctor holds the transducer with her right hand against the pregnant woman's abdomen, while marking the beginning of a new section of their ongoing activity, by saying *hai* ("Okay").

Extract 16 [BB: 1]

- 01 DOC: *hai, °ee::: tto::°*
 OK uhm
 "OK. Uhm"
- 02 (1.0)
- 03 PWM: → (*m::*) *minna ni ʔonaka ʔga chicchai 'tte iwareru=*
 everybody by stomach P small P be-told
 "((I) am told by everyone that ((my)) stomach is small,"
- 04 DOC: *ʔn? ʔnn,*
 huh? yeah
 "Huh?" "Mm hm"
- 05 PWM: → *=kara, chicchai no kana: to omot'tari*
 because small P wonder P think
- 06 → *ʔ(shi te ru n'desu kedo:)*
 be-doing JD though
 "so ((I) am thinking ((it is)) small,"
- 07 DOC: *ʔiya: demo hora, kawa ga anmari nai kara.*
 no but INT skin P only-few because
- 08 *ano, mina san omanjuu no kawa ja nai kedo,*
 uh everybody steamed-bun P skin JD NG though
- 09 *.h soto gawa ga futo 'cchatte, sorede ano::,*
 outside P fat became then uhm
- 10 *.h ookiku mieru no yo. ʔsorede-*
 big look P P and
 **"No. But, look, the skin is very thin, so. Uh, everybody's
 outside gets thick, like the skin of a steamed bun, and so
 ((their stomachs)) look big."**
- 11 PWM: *ʔsoto gawa?*
 outside
 "Outside?"

Strikingly, not only is the sequential position of the problem-presentation initiation similar to the one in Extract 2, but here also the pregnant woman uses almost the same problem-presentation construction as that used in Extract 2, that is, "**((I) am told by everyone that ((my)) stomach is small.**" This report by the pregnant woman is also recognizable as an expression of a concern. Indeed, in response to the woman's report, the doctor shows her understanding that a problem has been presented by negating the problematicity of the woman's concern-so-understood. She (the doctor) does so explicitly, first with the negation token *iya* ("no") in line 07; and then with an account for the *appearance* of the stomach, namely, a non-problem-implicating account (introduced with the disagreement token *demo* ["but"]). In this section, I explicate some features of the

seriousness of the problem in their problem presentations. The construction of the problem presentation in Extract 1, an excerpt from a patient's visit to a gynecologist, is an instance for this ("No, uh, it seems like around the left ovary ((I)) occasionally have pain."). Indeed, the problem presentation is introduced with a negation token *iya* ("no") in line 13. Furthermore, the problem being presented is qualified in terms of frequency (*tama ni* ["occasionally"] in line 19) and certainty (*yoo na* ["like"] in line 19). With these practices, one should note, the patient still appears to be oriented to the legitimacy issue, by exhibiting an orientation to the problem's possible inappropriateness as the reason for the visit.

Certainly, pregnant women at regular prenatal checkups do not need to address the issue of the legitimacy of their visits, which are already legitimate insofar as they are only following their health-care professionals' instructions. Furthermore, most of their concerns to be presented during their checkup visits ought not to be the legitimate reasons for their visits. If they thought that these concerns could be the legitimate reasons for the visits, they should not have waited until these appointed visits, but should have come earlier. However, they still need to address another legitimacy issue, i.e., the issue of how to legitimize the initiation of this problem presentation precisely at this moment in this visit. This issue imposes some constraints on the construction of problem presentations in the course of the incipient activity. First, the problems need to be designedly presented as adequately minor (such as the apparent size of the woman's abdomen in Extracts 2, 16, and 17) or nonurgent (such as the previously found breech presentation in Extract 15) to avoid being a possible legitimate reason for an extra visit. Second, problem presentations during incipient activities in progress need to be designedly noninterruptive to the activity in progress (remember that in Extract 2, the midwife interrupted her ongoing activity, i.e., the measurement of the abdominal girth, actually to deal with the presented problem). Third, the problems still need to be presented as being worthy to be raised, particularly given that the health-care professional is observably engaged in another distinct activity. The avoidance of expressing a concern in so many words by the use of the reporting format contributes to a fulfillment of the first and second requisites.⁷ The formulation "everyone" offers a simultaneous fulfillment of the first and third requisites—it implies a claim that the problem is not so obvious to the woman herself, but that it is still noticeable to those who do not have a special interest in the pregnancy. The use of the reporting format with an extreme case formulation is one practice for "optimizing" orientations to these requisites.⁸

The Mutual Dependence of the Position and Design

Finally, note also that in the reporting format, the problem presentations are still only "possible" problem presentations in Sacks's (1992) sense. Whether the report, "((I)) am told by everyone that ((my)) stomach is small" recognizably constitutes a problem presentation may depend largely on the precise sequential position in which it is produced. (Suppose that, at a party for which she dresses herself up, a pregnant woman produces the same utterance, as an answer to her husband's question, "How have people been responding to your outfit?" The utterance would then be heard as an expression of relief.) Thus, the sequential position of the production is crucial to the utterance's status as a problem presentation, the position and design of the utterance being intimately interdependent

⁷The pregnant woman in Extract 2 also employs other practices for mitigating the seriousness of the possible problem, such as using *nanka* ("or something") at the beginning of line 01 and laughing during line 02 indicated by (h)'s (see Jefferson, 1984, 2004a, among others, for what she calls "trouble-resistance" laughter).

⁸Heritage (2002) and Boyd and Heritage (2006) provide a more technical discussion of the "optimization of preferences" in the construction of doctors' questions.

(see Sacks, 1992; Schegloff, 1997; Schegloff & Sacks, 1973; see also Peräkylä, 1998 for the relation between the construction of doctors' diagnoses and their placement).

RESPONSES TO SELF-INITIATED PROBLEM PRESENTATION

As we saw earlier, the pregnant women's problem presentations in Extracts 2 and 16 are constructed such that they incorporate a justification or defense for presenting *this* problem at *this* moment. This construction is achieved by the use of an extreme-case formulation that implies the groundedness on disinterested observations by adequately many people. This grounded or defensive nature of the construction makes it expectable for the health-care professionals to mobilize any available evidence, in responding to the problem presentation, particularly when the response is a no-problem one. In addition to the construction, the precise placement of the production of the problem presentations frames the way in which the health-care professionals should respond to them, by relating them to the concurrent incipient activities (measuring and palpating the woman's abdomen respectively). This placement makes it expectable to cite evidence from the measurement or palpation (or other functionally equivalent items) in support of the health-care professionals' claims in response to the pregnant women's problem presentations.

Indeed, as I mentioned previously, immediately before she negates the problematization of the presented problem, the midwife in Extract 2 torques her body and looks at the computer monitor behind her during the 4.2-second-long silence in line 04 (see Figure 3), thus *doing looking into possible evidence* within the pregnant woman's visual field. The midwife's conduct (i.e., doing mobilizing a piece of evidence) appears to be made relevant by the construction and the placement of the pregnant woman's problem presentation, though the evidence that she consults is not obtained from the activity in progress, i.e., reading the tape measure. (Obviously, the midwife consults stronger evidence than the abdominal measurement for her counterclaim to the concern raised by the pregnant woman, that is, the concern about the normality of the fetal development.)

A similar course of interaction is observable in the interaction whose segment was reproduced as Extract 16. Here, the pregnant woman initiated a problem presentation with the same construction precisely at the time that the ultrasound examination was getting underway. The construction and the placement of the pregnant woman's self-initiated problem presentation also appear to make it expectable for the doctor to provide evidence from the incipient activity, i.e., the ultrasound examination. Extract 18 is an extension of the health-care professional's response to the problem presentation in Extract 16.

Extract 18 [BB: 1: The continuation of Extract 16]

- 07 DOC: *Liya: demo hora, kawa ga anmari nai kara.*
 no but INT skin P only-few because
- 08 *ano, mina san omanjuu no kawa ja nai kedo,*
 uh everybody steamed-bun P skin JD NG though
- 09 *.h soto gawa ga futo 'chatte, sorede ano.;*
 outside P fat became then uhm
- 10 *.h ookiku mieru no yo. [sorede-*
 big look P P and
- “No. But, look, the skin is very thin, so. Uh, everybody
 ((whose stomachs)) looks big has a thick outside, like the
 skin of a steamed bun.”**

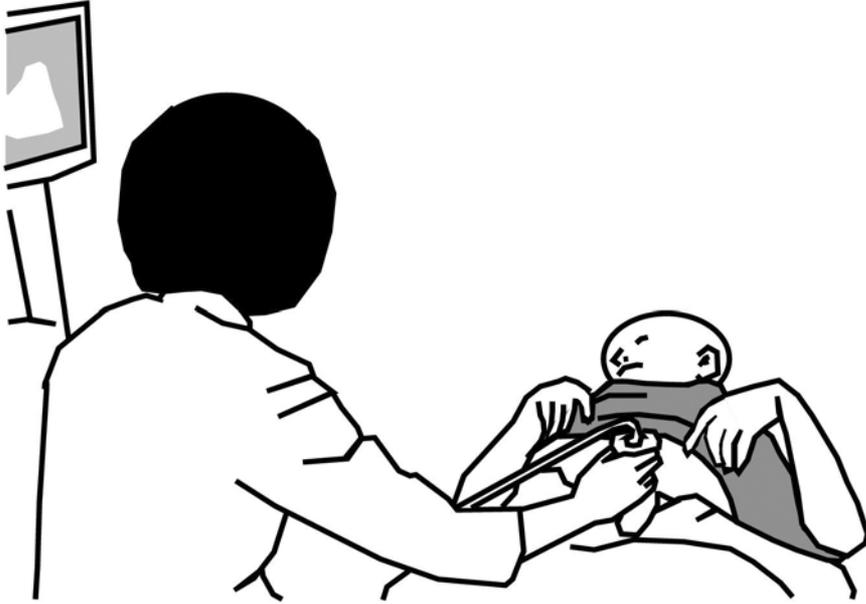


FIGURE 4 The doctor looks at the ultrasound monitor before she responds to the pregnant woman's problem presentation (Extract 16, line 01).

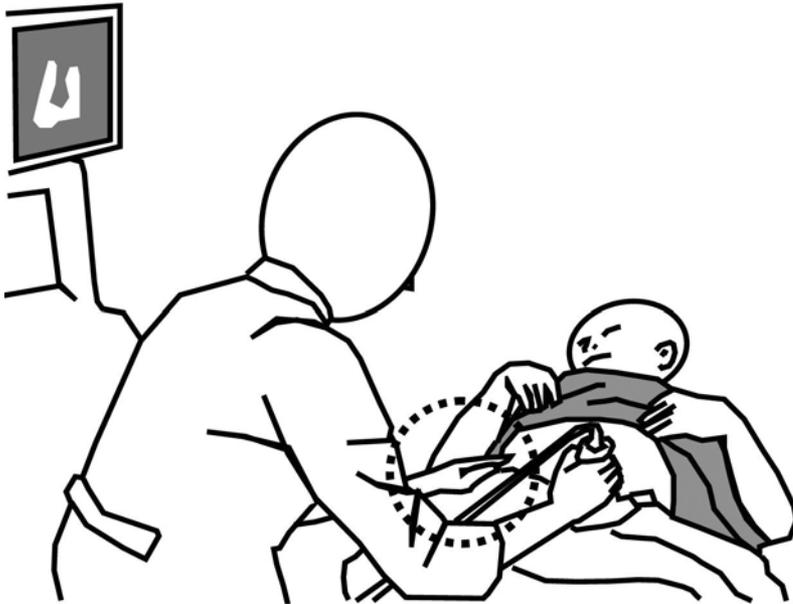


FIGURE 5 The doctor looks at the pregnant woman's abdomen and rubs it with her hand when she responds to the pregnant woman's problem presentation (Extract 18, line 07).

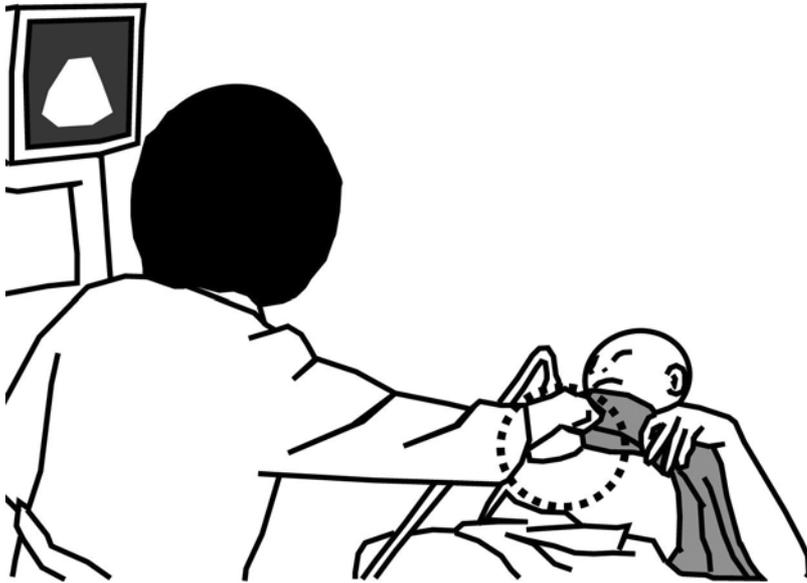


FIGURE 6 The doctor rotates the transducer on the pregnant woman's abdomen, while looking at the monitor screen (Extract 18, line 21).

monitor (and, therefore, to the incipient activity of the ultrasound examination), is remarkably reoriented towards the pregnant woman's abdomen. Thus, the doctor interrupts her incipient activity and, by rearranging her bodily orientation, displays her *inspecting* the skin of the pregnant woman's abdomen, thereby mobilizing evidence for her explanation in the pregnant woman's visual field in responding to the woman's problem presentation.¹⁰

Second, when the doctor demonstrates the normality of the uterine development in line 21 of Extract 18, she holds the transducer on the pregnant woman's abdomen and slightly rotates it while producing the deictic term *koko* ("here") (Figure 6). In doing so, she indicates the abdominal location of the uterine fundus (the upper end of the developed uterus). Note, however, that the doctor (as well as the pregnant woman) looks at the monitor screen as she rotates the transducer on the pregnant woman's abdomen. The demonstration of the normality of the uterine development is thus achieved through this pointing with the transducer being related to the image on the monitor screen. Indeed, pointing to the abdominal location of the uterine fundus does not by itself constitute a demonstration (at most it is only a claim) that the uterine fundus has reached the location being pointed to. It can only be a demonstration in conjunction with the image on the screen created by the transducer precisely as it touches the abdominal location in question.

Thus, the construction and the position of pregnant women's problem presentations are consequential to health-care professionals' ways of responding to them.

¹⁰Interestingly, the doctor also uses an extreme case formulation *mina san* ("everybody") in her explanation (in line 08).

RESPONSES FOLLOWING SEQUENCE COMPLETION AND A POSSIBLE DILEMMA

Second Responses

The interactional segment reproduced as Extract 2 is followed by a 10.2-second-long silence, during which the midwife completes measuring the fundal height. Extract 19 is the continuation of Extract 2; after the silence, the midwife provides an account for the appearance of the pregnant woman's abdomen.

Extract 19 [SU II: The continuation of Extract 2]

- 10 (10.2)
 11 MDW: *tabun koo (0.2) gyu 'tto tsumatte'ru n'ja nai*
 probably this-way MIM P packed JD NG
 12 *des' ka ne nakade aka rchan ga£*
 JD IG P inside baby P
**“Probably, ((it is)) packed like gyuu, I think. Inside
 ((the uterus)). The baby.”**
 13 PWM: L° *kana(hh)°?*
 IR
“Perhaps.”
 14 MDW: *u:n.*
 yeah
“Yeah”

The midwife suggests in lines 11–12 that the woman's abdomen looks small because the fetus is packed compactly inside the uterus, implying the normality of the fetal development. The pregnant woman registers this as a possibility (line 13). The precise timing of the production of the midwife's account may work to tie this account back to the measurement of the fundal height (which, presumably, indicates the normality of the uterine development). In other words, the midwife's utterance is constructed such that the provision of the account appears to be occasioned by a new piece of experiential evidence. This is the second negation of the problematicity of the pregnant woman's presented problem following a first complete response, occasioned by another distinct activity (i.e., measuring the fundal height).

This second response seems also to be procedurally grounded in the construction and placement of the original problem presentation. Because the problem presentation is produced with a defensive construction at an evidence-sensitive position, the midwife may be inclined to provide as many evidenced accounts as possible for the normality of the fetal development, even after having delivered one complete response.

A second response to a problem presentation is, indeed, observed in the same ultrasound examination as Extracts 16 and 18, around 3 min and 15 s later than Extract 18. After the doctor calculated the estimated fetal weight (“about one thousand three hundred ((grams))”) through the cross-section image of the fetal body, she negates the pregnant woman's concern again in Extract 20:

Extract 20 [BB: 1]

- 01 DOC: *son'na ni okkii hoo ja nai kedomo*
 (not-)so big rather P not though

- 02 >↑demo< *sen san byaku gurai no kanji ni:*
but thousand three hundred about P like P
- 03 (0.4) *na ɾru kara:*
be so
“Though not so big, ((it) is now one thousand three hundred ((grams)), so”
- 04 PWM: *La hai hai Lja 'son'na ni*
oh yes yes then (not-)so
“Oh yes yes. Then ((it is)) not so”
- 05 (.)
- 06 DOC: *ɾson'na ni chicchaku na ɾi:. n::n.*
(not-)so small not yeah
“not so small, yeah.”
- 07 PWM: *L^on^o L^osoo desu yo ɾne^o*
yeah so JD P P
“yeah.” “That’s right.”
- 08 DOC: *L^odakara*
therefore
- 09 *ano: .hh ee:to onaka chicch^{ai} tto yuu no to:*
uh well stomach small called and
- 10 *nakami ↓ga chicch^{ai} tto yuu no to*
contents P small called and
- 11 *ma ɾta chigau ka\ra. ɾ*
quite different so
“So uh the stomach being small and the contents being small are quite different things.”
- 12 PWM: *L^omattaku: kan^lkee nai no?*
(not-)at-all related not P
“are not related at all?”

It is easy to see that when the doctor says that the pregnant woman’s abdomen is “not so small” in line 06, she is responding to the pregnant woman’s earlier concern. The relevance of mentioning, with a negative formulation, the *nonsmallness* evidently comes from the pregnant woman’s previously stated concern about the small size of her abdomen. Furthermore, as a conclusion derived from this utterance in line 08 (marked with *dakara* [“therefore”]), the doctor mentions the difference between the outer appearance and the actual contents in lines 09–11. Mentioning this difference, the doctor hearably refers back to what she (the doctor) said immediately following the pregnant woman’s problem presentation in Extract 16. Thus, we find here another instance of a second response to a problem presentation. This second response in Extract 20 is also occasioned by a new piece of evidence for the “no-problem” diagnosis.

Resistance or Excuse?

In the remainder of this section, I will show that the procedural grounds for the production of second responses to self-initiated problem presentation may lead to a dilemma. Extract 21 is an extension of Extract 19, which was a continuation of Extract 2.

Extract 21 [SU II: An extension Extract 19]

- 10 (10.2)
- 11 MDW: *tabun koo (0.2) gyu 'tto £tsumatte'ru n'ja nai*
 probably this-way MIM P packed JD NG
- 12 *des' ka ne nakade aka £chan ga£*
 JD IG P inside baby P
**“Probably, ((it is)) packed like gyuu, I think. Inside
 ((the uterus)). The baby.”**
- 13 PWM: $\text{L}^{\circ}\text{kana}(\text{hh})^{\circ}?$
 IR
“Perhaps.”
- 14 MDW: *u::n.*
 yeah
“Yeah”
- 15 (2.6)
- 16 PWM: *koo odorokareru n'desu yo £ne? ittsumo:£ £(hh).*
 this-way surprise JD P P always
“Well, ((I)) surprise ((everyone)), always.”
- 17 MDW: $\text{L}_n :: :: :: :: \text{J} \text{L}_n$
 yeah yeah
“Yeah.” “Yeah.”
- 18 PWM: *.hh raigetsu shussan te yuu £t'. £*
 next-month delivery P say P
“when ((I)) say the delivery is expected next month.”
- 19 MDW: $\text{L}_n :: :: \text{J} n$
 yeah
“Mm hm”
- 20 PWM: *.hh [hh*
- 21 MDW: $\text{[} > \text{tashikani soo desu ne. =kojin} < \text{mari to shiteru ke} \text{J} \text{do:}$
 certainly so JD P compact P be though
“Certainly it is. ((It)) looks small, but,”
- 22 (0.4)
- 23 PWM: *.hh (s)hitorime n'toki mo chicchaka tta n'desu £kedo:*
 first P time also small was JD though
**“When ((I)) had the first ((child/baby)), ((it/he/she)) was
 small, too.”**
- 24 MDW: $\text{L}_n :: :: n =$
 yeah
“Mm hm”
- 25 MDW: *demo:: hitorime no okosan betsuni*
 but first P child (not-)particularly
- 26 *futsuu no £ookisa£ deshita £yo ne: £*
 normal P size was P P
“But the first child was normal in size, wasn't it?”
- 27 PWM: $\text{L}_m\text{-ma} \text{J} \text{L}_{\text{gi-girigi}} \text{J} \text{ri}$
 well barely

- 28 *gura(h)i(h ɾh) gh ɿ GHGH ((coughs))*
 about
 “Well, just barely.”
- 29 MDW: $\perp_{n:::n} \downarrow$
 yeah
 “Yeah.”

After the midwife produces a second response in lines 11–12, the pregnant woman simply registers the midwife’s conjecture without fully agreeing in line 13 (“Perhaps.”). The pregnant woman then produces the utterance in lines 16 and 18 (“Well, ((I)) surprise ((everyone)), always, when ((I)) say the delivery is expected next month”). Some features of this utterance are: First, it is produced at a sequential position where it can be related to the pregnant woman’s not having fully accepted the midwife’s conjecture. Second, she does not overtly say what she surprises everyone with, indicating that this utterance is designedly dependent on a prior utterance (shown as lines 01–02 of Extract 2). Being related to this prior utterance, she can be heard as meaning that she surprises everyone *with the smallness of her stomach*. The utterance in question can thus be heard as an extension of the pregnant woman’s own prior utterance in which she presented a problem. Third, during the 2.6-second-long silence in line 15 (Extract 21), the midwife performs abdominal palpation, starting with the buttocks of the fetus, which is the uppermost fetal part (Figure 1). The pregnant woman times her utterance to start precisely when the midwife holds the fetal head, which is the lowest part and possibly final item of the current palpation, with her right hand. Hence the pregnant woman produces her utterance at a sequential position where the midwife can be seen to have just located the entire body of the fetus.

Taken together, the utterance in lines 16 and 18 can be heard as a second (upgraded) attempt at the presentation of the same problem following the negation by the midwife of its problematicity. Furthermore, after obtaining a concession from the midwife in line 21, the pregnant woman launches an utterance which is hearable as providing another piece of evidence for her concern in line 23,¹¹ where she mentions the fact that when she had her first child, it was small. This utterance (line 23) can also be understood as resistance to the midwife’s previous no-problem response.

Indeed, the midwife subsequently orients to this as resistance—after her acknowledgement in line 24, she first marks what follows as a disagreement with *demo* (“but”), and then invokes the fact that the pregnant woman’s first child was “normal” (*futsuu*) in size (lines 25–26). Moreover, as she does so, the midwife torques her upper body again, keeping her hands on the pregnant woman’s abdomen, to look at the computer monitor behind her (Figure 7). The midwife, in doing so, visibly grounds her no-problem conclusion on the available evidence (a course of action that is very similar to lines 04–06 of Extract 2), exhibiting her understanding that the pregnant woman has resisted the no-problem response and reattempted her problem presentation.

However, there is another possible description of what the pregnant woman does, which can be also grounded upon the procedures that I have explicated. We saw that pregnant women constructed their problem presentations by employing various practices to address the issue of legitimizing the presentation of a problem at that particular moment. In the context of a no-

¹¹During the utterance in line 21 and the 0.4-second-long silence in line 22, the midwife keeps palpating the pregnant woman’s abdomen. In particular, given the format “Certainly X but Y,” the midwife’s continuation of the palpation during the small silence following the concessive utterance in line 21 foreshadows her mentioning of a fetal condition, which further negates the problematicity of the presented problem. The pregnant woman’s utterance in line 23 also appears to preempt this foreshadowed negation.



FIGURE 7 The midwife looks at the computer monitor behind her again
(Extract 21, line 25).

problem response, more work may be necessary by the pregnant woman to legitimize her original problem presentation. Indeed, the pregnant woman's utterances in lines 16, 18, and 23 of Extract 21 can also be heard as an excusatory account for having raised this concern at this moment, rather than *redoing* the problem presentation and resisting the no-problem response. By citing "everyone's surprise" and the fetal condition during her first pregnancy, she possibly accounts for raising her concern, defending against any possible suspicions that she might be a "worrywart."

If the pregnant woman's utterances in lines 16, 18, and 23 of Extract 21 are produced as a further defense, addressing the legitimacy issue, a dilemma may be intrinsically involved in self-initiated problem presentation at a particular, but systematic sequential position. I elucidated in earlier sections the procedural ground for the defensive construction of problem presentations. This same procedural ground can also be one for the production of a further defense in response to a no-problem response given by a health-care professional to the original problem presentation. However, this defensive response by a pregnant woman is also hearable as a second attempt at the same problem presentation precisely because of the procedural ground for its construction, and therefore may solicit a further no-problem response from the health-care professional. This second no-problem response, in turn, occasions yet a further defensive response, i.e., the provision of another excusatory account for the production of the original problem presentation. Indeed, the pregnant woman's utterance in lines 27–28 of Extract 21 can be hearable as providing an excusatory account for mentioning the fetal condition during her first pregnancy, by saying that though the first child fell within the "normal range," it was nevertheless a borderline normality. The more defensive a pregnant woman becomes in providing excusatory accounts for her original problem presentation per se, the more negations of the problem are solicited—leading to a cycle of defenses and negations. The

possibility of the occurrence of this cycle appears to be systematically provided by the normative order of interaction in regular prenatal checkups.

CONCLUDING REMARKS

I have demonstrated that during regular prenatal checkups, a systematic position in which pregnant women may initiate the presentation of a concern is where an incipient activity is in progress, and that the orderly features of the construction of their problem presentations produced at this location, and the orderly features of the placement of the presentation, are mutually constitutive. However, these features may lead to a dilemma. In this concluding section, I explicate implications that the present study may have for the study of medical interaction in particular and the study of human interaction in general.

It is well-known that Mishler (1984) points out various discrepancies between patients and medical professionals and attributes them to the differences between patients' voice of their life world and medical professionals' voice of medicine. According to Mishler, interactional mishaps may be caused by the mismatch between patients' ways of talking, which originate in their ordinary lives where the problems occur, and the medical context in which such problems must be presented. In other words, patients' voice of the life world does not fit well in a context where the voice of medicine is dominant. I have demonstrated, on the other hand, that an interactional mishap can also be procedurally grounded in the organization of interaction in prenatal checkups (in Extract 21 a negation of the pregnant woman's presented problem occasions the woman's further defensive accounts, which, in turn, solicits a further negation of the possible problem). The possibility of the mishap is a structural feature of interaction in prenatal checkups, rather than a difference in participants' supposedly pre-given attitudes toward the possible problems patients may have, and can only be revealed through a detailed analysis of concrete interaction.

I would also like to emphasize the multimodality of action formation demonstrated in this account of how and when pregnant women present their concerns. While focusing on actions whose achievement depends crucially on linguistic resources, such as problem presentation and negation of the presented problem, nonverbal resources, such as the coparticipant's (visually accessible) activities of measuring a pregnant woman's abdominal girth and preparing for an ultrasound examination, are just as crucial for the formation of pregnant women's recognizable problem presentations. As Goodwin (2000, 2003a, 2003b among others) clearly shows, in our lived world, with multiple bodies and various objects, action formation is accomplished through the spatiotemporal juxtaposition of talk, bodily movements and postures, and tools and various material objects (see also Nishizaka, 2003, 2006; in particular, for an analysis of the work of fine coordination to obtain a mutual accessibility to coparticipants of visual resources, such as hand gestures, see Heath, 1986; Streeck, 1996, 2008, among others).

Furthermore, touch is a neglected modality of orientation in interaction studies. The force of the doctor's demonstration of the abdominal location of the fundal height in Extract 18, however, depended crucially on the pregnant woman's seeing the image on the ultrasound monitor and feeling the transducer on her abdomen. Indeed, for the formation of some recognizable actions to be accomplished, what one participant feels tactually may also need to be felt and/or seen by the other participant(s). Action formation in prenatal checkups is an essentially multisensory achievement in interaction (see also Nishizaka, 2007). This is a very complex achievement. What I have

demonstrated here is that this complex achievement is, nevertheless, the product of a methodically organized set of practices, which are describable in an orderly way.

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