Weighing in primary-care nurse–patient interactions

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Abstract

This article analyzes the interactions through which primary-care nurses and patients accomplish patient weighing. The analysis is based on videotaped nurse–adult patient interactions in clinics in the area of Southern California. Detailed examination of co-participants’ naturally situated weighing conduct shows that parties recurrently deliver utterances that go beyond that required to accomplish weight measurement—precisely “where” they “are” within the weighing process shaping how they produce and understand these utterances. Using weighing as a locus of epistemic negotiation and potential affiliation, co-participants interactionally achieve the distribution of weight/weighing knowledge and the character of their social relationship. Confronting their numerical weight results in a social/medical setting, patients can use expansive weighing utterances to claim or demonstrate that they possess pre-existing knowledge regarding weight, asserting independent expertise vis-à-vis nurses and claiming result co-recipiency and co-ownership. Speakers can also use expansive utterances to proffer an interactional opportunity for affiliation, inviting recipients to collaborate in producing a more personalized encounter. Through the acceptance or declination of these invitations, the parties work out “who” they “are” to and for one another.

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Introduction

Primary-care nurse–patient interactions in the US regularly begin when nurses or medical assistants1 call patients’ names, summoning them into the area of the medical office housing exam rooms and medical equipment. Nurses then lead patients, physically and interactionally, through a set of discrete tasks that together constitute a “goal-coherent course of action” (Heritage & Sorjonen, 1994). The “goal” is for nurses to ascertain patients’ measurable signs (i.e. health indices) and stated symptoms (i.e. presenting concerns), recording in patients’ charts “how” they are “doing” in the here-and-now2 for physicians’ use during the subsequent physician-patient interaction.3

During nurse–patient encounters, nurses routinely measure and record patient weight, temperature, blood pressure and pulse. Weight is the sign frequently measured first.4 This article provides an analysis of the interactions through which nurses and patients accomplish patient weighing.

1Henceforth, “nurse” includes nurses and medical assistants.
2Nurses can also ask patients medical history-taking questions (e.g. age, allergies).
3For discussion of how nurse–patient interactions can shape subsequent physician–patient communication, see Heritage and Robinson (in press).
4Of the 81 weighings examined, 71 were done “first.”
While previous studies have used attitude/behavior questionnaires (e.g. Friedman, Reichmann, Costanzo & Musante, 2002; O’Dea & Caputi, 2001) and body silhouettes/drawings (e.g. Demarest & Allen, 2000; Jackson, Rashed & Saad-Eldin, 2003) to investigate perceptions of body shape/size and weight (often in relation to eating disorders), none have directly observed persons responding to the measurement of their own numerical weights. Recent literature has explored the influence of individuals’ sizes/weights on physician–patient interactions (Krainin, 2002) and retail interactions (King, Shapiro, Singletary, Turner & Hebl, 2005), but these studies do not directly show how participants naturally occurring weighings display their own orientations toward weight. The present study addresses this gap by examining the specific details of co-participants’ naturally situated interactional conduct during weighing, showing how persons-as-patients manage confronting their numerical weights in a social (i.e. vis-à-vis co-present nurses), medical setting.

Although the interactions through which patients’ weights are ascertained are heretofore unexamined, Pomerantz and Rintel (2004) have investigated practices for reporting and responding to measurements of other health indices (e.g. blood pressure, temperature) during physician-patient encounters, showing how physicians can proffer or patients can request interpretations (i.e. explanations/translations/assessments) of raw numerical results that enable patients to understand their import for their state of health. Through these actions, co-participants display their orientation to an asymmetry of medical knowledge, interactionally constituting physicians as authoritative medical experts from whom patients can (and perhaps should) acquire expertise so as to “become increasingly able to interpret indices of their states of health” (Pomerantz & Rintel, 2004). In contrast, during nurse-patient interactions, co-participants treat raw numerical weights as transparent, readily understandable to patients without interpretation by nurses. This suggests that parties orient to patients as possessing pre-existing, independent knowledge regarding weight. This article provides further evidence of this orientation, showing that patients do interactional work to claim or display that they know about their own weights vis-à-vis nurses, a finding that has implications for the balance of epistemic authority in nurse-patient encounters.

While previous conversation analytic work has demonstrated participants’ orientation to asymmetries of medical knowledge and authority in physician-patient interactions (Gill, 1998; Heath, 1992; Maynard, 1991; Peräkylä, 1998), there is presently a dearth of analogous research on nurse-patient interactions, especially in primary-care. The nurse-patient “power relationship” has, however, been explored in hospital health counseling sessions (Kettunen, Poskiparta & Gerlander, 2002) and via comparison between experienced and inexperienced nurses delivering in-home and residential aged-care (Candlin, 2002). Noting some interactional resources available to patients for minimizing power asymmetry between themselves and nurses, Kettunen et al. (2002) observe, “power is a complex and polysemic phenomenon that can be created jointly.” The present article complements and extends this previous research by examining the interactional work co-participants do during weighing to manage how they relate to one another, negotiating both the distribution of knowledge/expertise regarding weight/weighing and the character of their social relationship during the weighing process.

**Description of weighing**

Recurrently launched by nurses, weighing requires patients to transition from standing on the same physical level as nurses to standing up on the raised, stage-like platform of the scale where they are available for nurse (and self) inspection. This sets up an experiential or perspectival asymmetry between the two parties, casting the nurse-as-“weigher” (observer) and the patient-as-“weighed” (observed object). Another asymmetry arises from patients’ and nurses’ divergent perspectives vis-à-vis the medical organization: as institutional representatives, nurses generally participate in several patient weighings as part of their daily work, orienting to patients as “routine cases” (Drew & Heritage, 1992). As “clients”, however, patients orient to their own weighing experiences as comparatively “unique and personal” (Drew & Heritage, 1992); though they may have past experience having their weights measured, over the course of their patient “careers” they experience significantly fewer weighings than do nurses. While such experiential or perspectival asymmetries may inform the nurse-patient relationship, they by no means determine it; rather, as this article shows, co-participants choose–on a moment-by-moment basis–how they relate to one another.

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7Including (but not limited to) understanding how to do “being weighed” and interpret one’s own numerical weight result based upon prior understanding of one’s own normative weight (number/range).
Weighing may be distinctive among the signs ascertained during nurse–patient encounters in that, during measuring, patients frequently have, along with nurses, concurrent perceptual (visual) and epistemic access to the displayed result\(^8\) (often not the case during temperature, pulse and blood pressure measurement), knowing how to both read and interpret weight results independently. The type of scale used can impact the readability of the display and the measuring process involved, factors that themselves can impact the course of the weighing interaction. Beam scales require a participant’s manual adjustment of sliding, head/shoulder-level counterweights, whereas floor scales, which tend to have hip/foot-level displays, automatically and immediately begin measuring weight when patients step onto their platforms, displaying a numerical range before ultimately settling on a single weight result.

“Who” or “what” is constituted as a proper recipient of the weight result is subject to interactional negotiation. Nurses comport themselves as conduits, measuring patient weight to record results in patients’ charts for use “not now” but in the future (most proximally by physicians during their encounters with patients, but also as part of an ever-accumulating patient dossier). Nurses can move to (or can opt not to) include patients as co-recipients of their weights, and patients can work to claim co-recipiency, asserting result co-ownership by displaying “interest” in their weights (c.f. Pomerantz & Rintel, 2004).

A fundamental finding of the present research is that co-participants recurrently deliver utterances during weighing that go beyond that required to accomplish the immediate institutional task of weight measurement.\(^9\) Precisely “where” they “are” (i.e. which “slot”, see Fig. 1) within the weighing process shapes how they produce and understand these utterances. This article examines what co-participants are doing interactionally by delivering such utterances.

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\(^8\)Patients usually do not have independent access to the results nurses record in their charts, however; see Example 1.

\(^9\)Recurrently, but not invariably; Example A shows parties doing weighing without delivering utterances beyond that required to accomplish weight measurement.

**Example A [10–01]**

1 MA: Check your weight,
2 (4.2)/((PT places jacket on table, then steps onto beam scale))
3 MA: Scoot up jus’ a tiny bit more,
4 (0.5)
5 MA: Put shyour feet together (an’ let’s see/for me/okay)?
6 (8.5)/((MA adjusts counterweights))
7 MA: ptch! “(Two hundred./Okay.)”
8 (1.2)/((MA resets counterweights))
9 MA: Go ahead.Step do:wn?
10 (2.8)/((MA writes in chart))
11 MA: An’ we’re waiting on a blood pressure machine.
Data and method

Data are 81-videotaped nurse–patient interactions representing 19 clinics drawn from a larger corpus of primary-care patient visits collected in Southern California in 2002–2003. All data collection was done under approval of the University of California Los Angeles Office for Protection of Research Subjects. The author analyzed the data using the methods of conversation analysis, transcribing the interactions using the system developed by Gail Jefferson (explicated in Atkinson & Heritage, 1984). Conversation analysis enables researchers to closely attend to the details of how co-participants demonstrably make sense of one another’s interactional conduct.

Analysis

Weighing as a locus of epistemic negotiation and face-work

Through their talk during weighing, parties can make explicit the type of numerical weight result they regard as accurate, desirable or “good”, or alternatively inaccurate, undesirable or “bad”, thereby demonstrating their moral orientations toward weight. Inextricably linked to this is patients’ observable concern to preserve or otherwise manage their image of self or “face” (Goffman, 1967) when publicly (vis-à-vis nurses) confronted with their weight results. Patients can treat results as face-affirming or face-threatening depending upon whether they are congruous or incongruous with their own expectations.

Consider Example 1. The patient (PT) is fully on the platform of the scale by line 8. During the silence at line 9, the video shows the nurse (NR) gazing at the scale display and then turning his gaze toward PT’s chart, starting to write. It is while NR is writing, apparently starting to record the displayed weight result in PT’s chart, that PT delivers her utterance at line 10. (Target lines are bolded.)

Example 1 [19-01]

1  NR: Hello,
2     (3.3)/(NR gestures toward scale; PT puts purse and coat down on chair)
3  NR: .nhhh!
4     (3.2) ((PT walks to floor scale))
5  PT?: °°° ((PT steps onto scale))
6     (1.2)
7  PT?: ptch! .nhhh!
8     (1.3)
9
10  PT: It’s dark back here. Don’t get it more than it is.
11     [(NR gazes toward scale display)]
12  NR: =<Okay,>
13  PT: hih hi[h hih .nhh!
14     [((NR reaches arm to scale display)]
15  NR: I’ll (haf-) double check it >b’her I
16  write anything down.

10 This article presents 14 data exemplars featuring 14 adult patients with the following apparent characteristics: six male, eight female; in terms of age, four in their 20–30s, seven in their 40–50s and three in their 60–80s; three African–American, two Asian–American, seven Caucasian and two Latino/a. Such diversity suggests the findings of this research apply to many different “types” of person, possibly challenging vernacular Western assumptions about how issues around weight might be gendered (e.g. relevant predominantly to females; cf. Henslin & Biggs, 1971), weight-specific (e.g. relevant predominantly to perceivably overweight individuals) or otherwise stereotypically associated.

11 Less standard transcript symbols are “z” indicating intonation between continuing and rising, and “!” following an abruptly punctuated sound.

12 During the acute primary-care visits examined, weight appears to be the sign parties most often treat as moral, volitional and accountable. Different orientations may be operative in chronic care visits, however. For example, in the case of hypertension, parties may treat high blood pressure as moral if it implies a lack of patient compliance with doctor’s orders to take prescribed medications and/or adhere to dietary restrictions/exercise regimens.
Registering the description, “It’s dark back here,” PT accounts for her incipient injunction to NR to not “get it more than it is”–“it” referring to the weight result NR is about to record in her chart. In this utterance, PT invokes two potentially independent versions of her weight, juxtaposing her implied pre-existing knowledge of what her weight is with what it may be found to be by NR. PT thereby treats a result that is “more than” what she expects as undesirable (she does not tell NR “Don’t get it less than it is”). Indeed, PT presents the darkness as a preemptive account such that if the result found by NR is more than what PT expects, that discrepancy will be attributable to the scale’s impaired visibility/readability. PT’s juxtaposition also implies her readiness to treat NR’s version as liable to being inaccurate, rather than her own version of what it simply “is.” It is only after NR starts to respond to PT’s command at line 12 (a response he continues at lines 14–16), displaying his orientation to its potentially serious import (as a bid to have him “double check” the result), that PT produces laugh tokens (line 13), working to mitigate her prior utterance’s hearable challenge to NR’s medical authority by retroactively marking it as possibly non-serious.13

PT’s gaze is focused on the scale’s display throughout her time on the scale, including as she asks NR, “Wha:t i:s it.hh” (line 17). If PT can read the numbers displayed, it is possible that her inquiry is less about soliciting help in reading the scale and more about gaining epistemic access to what NR is recording in her chart. After NR reports the result he has gleaned, PT receipts it with “Okay,” a sequence-closing third (Schegloff, 1995) token that, in this position, also carries the import of “I accept or approve of that.” Thus, during this sequence, the co-participants are (hearably) interactionally negotiating the balance of epistemic authority between themselves regarding weight.

In Example 1, PT invokes two versions of her weight as an interactional device through which she works to preemptively manage the face-threatening potential of a “too high” weight result. In Examples 2 and 3, patients who explicitly announce their expectations for their weights well before the scales register the results—delivering them as bets or predictions—retroactively do “defensive” face-work (Goffman, 1967) to manage discrepancies between their bets and the results found by nurses.

Example 2 [19-08]

1    (1.2)/((PT walks toward scale))
2   P?:   °Ayehh°
3    (1.1)
4   PT:   One ninedy fi::ve.hh=  
5   NR:   =Le::t’s see. ((NR brings pen to chart))  
6    (1.3)/((NR and PT do looking at scale display))  
7   NR:   Almo:st, ((NR gazes at chart))  
8    (1.3)/((NR writes in chart, then gazes at scale))  
9   NR:    ↑Okay.  
10  PT:   ((Whatsit-) Whudja get. ((PT gazes at scale))  
11  NR:    .hh One ninedy eight and [a half.  
12  PT:    [0::h? 0[ne ninedy ei::ght. 0:h.  
13  NR:    [[hh! hih hih! °nih°  
14  PT:    Small (putatuhs¡)

In physician–patient interaction, Haakana (2001) has shown that patients can use laughter to both display awareness of their utterances as delicate and remedy interactional “problems.”

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13In physician–patient interaction, Haakana (2001) has shown that patients can use laughter to both display awareness of their utterances as delicate and remedy interactional “problems.”
Example 3 [17-02]

1 NR: °Okay.°=Can I _take your weight?:?
2 PT: °Su:re.° .nhh!
3
4 PT: hhhh!
5 (2.1)/{(PT steps onto beam scale)}
6 (0.7)/{(NR slides counterweights)}
7 PT: .nhh!
8 (3.1)/{(NR slides counterweights)}
9 PT: On:e sixty: se#v en.°
10 (6.2)/{(NR slides counterweights)}
11 ((click sound as NR bends at waist to check PT’s foot
12 placement on scale platform))
13 (4.0)/{(NR resumes counterweight adjustment)}
14 [((two click sounds; NR gazes at PT’s feet))
15 NR: [(Are you-) Are you standing (it/there)?
16 NR: (Mo[ve/Come) (a little bit/forward).
17 PT: [((PT moves forward on platform))
18 (2.0)/{(NR slides counterweights)}
19 (4.7)/{(NR suspends hand in air waiting for counterweights
20 to balance})
21 NR: °(One/nine) (seven)?°
22 (1.3)/{(NR and PT turn to leave scale)}
23 PT: >Got on< my clo_thes? My clothes is heav(hh)y.hh=
24 NR: Gained (seven/several/some) pounds?
25 NR: =hhuh huh huh
26 PT: [.nhhh
27 (1.8)

In Example 2, PT launches his utterance at line 4 into the during-stepping on slot, just as he is starting to place his weight on the floor scale. Through this sequential placement of his utterance, PT appears to be “placing a bet” about what the result will be and correlatively “should” be. By announcing a number, PT is working to display his pre-existing, independent knowledge of his weight, conveying how regular it is and how well he knows himself. At line 5, NR’s utterance acknowledges PT’s bet while counterbalancing his asserted epistemic authority by conveying that she intends to check, formulating this as something they can do together. During the silence at line 6, NR apparently sees PT’s weight result displayed on the scale, which she indexes at line 7 with “Almost,” a conciliatory response to PT’s earlier wager. By moving to close the sequence with “Okay” at line 9, NR is choosing not to announce the result, for doing so in such a sequential environment would be tantamount to doing a dispreferred other-correction of PT.

In overlap with NR’s move to close, however, PT launches a turn with what sounds like a compressed “What is it.” PT then does a cut-off self-repair initiation, restarting his turn to instead ask, “Whudja get.” In doing this inquiry restart and reformulation, PT treats the result NR has gleaned from the scale as momentary, independent of what his weight “is.” PT’s subsequent response accepts the correction (via his repeat of a portion of the number), but he places his acceptance in between two sound-stretched “oh”s. In concert with his disattention to the “and a half” portion of NR’s finding and his utterance at line 14, these work to trivialize the discrepancy.

In a similar turn design to that seen in Example 2, PT in Example 3 delivers his “bet” for his weight at line 9 into the during-measuring slot. Although NR delivers the number quietly at line 21, it is clear from lines 23–25 that the result found is higher than PT wagered (indeed, NR may very well produce the result quietly because it is both different and higher than PT’s bet and thus constitutes a dispreferred other-correction). At line 23, PT delivers an account for the discrepancy, one that works to preserve his predicted weight as still “accurate” vis-à-vis NR’s announced result. PT uses “heav(hh)y” clothes as an innocuous, face-saving account that preserves his self-image by thwarting the potentially face-threatening discovery that he weighs more than he expected—a revelation that would cast doubt on his self-knowledge.

Even though the patient in Example 4 does not explicitly predict her weight, she does defensive face-work, both preemptively and retroactively, to manage an emergent discrepancy between her expectation and the result.
During the silence at line 9, PT gazes at the counterweights as NR slides them, delivering her utterance at line 10 just as she sees NR push a counterweight beyond the point corresponding to the weight she expects (thus parlaying her concurrent perceptual access, along with NR, to the scale’s display). Seeing that NR is about to find a higher-than-expected result, PT looks at NR as she says, “Oh, Your scale cheats.” PT is crying foul play, attributing ownership of the scale to NR (and the institution she represents) and working to challenge and de-legitimize the projected result. PT is also preemptively accounting for the imminent result by anthropomorphizing the scale—though inanimate, through PT’s utterance it becomes capable of “cheating.”

At line 12, NR produces laugh tokens (responsive to line 10) only once she is satisfied she has found the final weight result, and then at line 13, she delivers a rebuttal to PT’s challenge/accusation. At line 16, PT accounts for her previous utterance and extends her challenge of NR by invoking two independent versions of her weight, stressing “home” to contrast the result she finds there with the one NR has found here, in the medical office. At lines 18–22, PT then accounts for the discrepancy she claims exists by attributing the difference to her clothes. The laugh tokens infiltrating and bookending PT’s talk (lines 16, 18 and 22) mark it as possibly non-serious while simultaneously treating her account/challenge of NR as a misdeed (cf. Haakana, 2001).

At lines 24 and 26, NR does mock acceding, demonstrating her understanding of PT’s prior talk as implicitly requesting/demanding that she give PT a “discount” on her weight, “knocking off” six pounds before she makes it “official” by recording it in PT’s medical chart. By including herself in the “deal”, NR portrays PT’s request/demand as unreasonable while conceding that clothes/shoes are nevertheless convenient, attractive accounts for weight.

Like the patient in Example 3, PT in Example 4 delivers an account for the claimed weight discrepancy that works to preserve her expected weight as still “accurate” vis-à-vis the result NR has found, thereby thwarting the potentially face-threatening discovery that she weighs more than she expects—a revelation that would call into question her self-knowledge. By invoking her weight at home, PT presents herself to NR as the type of person/patient who weighs herself, displaying that she both possesses pre-existing, independent knowledge about her weight and is “interested” in tracking this index of her health status over time (cf. Pomerantz & Rintel, 2004). PT thus casts herself as an “active
patient” inhabiting the “independent expertise role” (cf. Pomerantz & Rintel, 2004), presenting herself as a proper monitor of her body (cf. Halkowski, in press). In addition, by attributing the alleged weight discrepancy to her clothing, PT provides an innocuous, face-saving account that works to preserve her self-image.

Like Example 4, Examples 5 and 6 also show parties haggling over weight. In Example 5, PT attempts to launch a negotiation at line 5 within the during-stepping on and pre-measuring slot.

Example 5 [20-07]
1 NR: I need you right on top (a/u) that scale please,
2 PT: **(Okay.)**
3 (3.0)/((PT places purse and jacket on table))
4 (0.4)/((sound of PT stepping onto floor scale))
5 PT: *I get tih take eight pounds off for my shoes.
6 ((PT launches this utterance after starting to step onto scale but before bringing her second foot completely up on platform to meet her first foot))
7 (2.2)/((NR does ‘looking at’ scale display))
8 NR: O:::k.

NR’s “O:::kay.” at line 10 is delivered as a sequence-closing token indexing that she has registered PT’s weight result, not as a response to line 5. Although NR declines to respond to PT’s discount entitlement assertion, PT’s utterance nevertheless preemptively provides an innocuous, face-saving account (her shoes) for eight pounds of her weight.

The co-participants in Example 6 enter into a mock negotiation in large part due to PT’s work to keep the during-result and post-result slot open for possible interactional expansion. At line 2, NR moves to close the weighing task by delivering the sequence-closing token “O:ka::y?hh” and directing PT onto the next task: having his blood pressure measured. At line 3, the video shows PT remaining on the scale platform and crouching to see the displayed weight result, thereby delaying his compliance with NR’s direction to follow her.

Example 6 [18-01]
1 (5.1)/((NR sliding beam scale counterweights))
2 NR: O:ka::y?hh .hh (. This wa:y? ((NR retreats from scale))
3 (2.4)/((PT remains on scale; looks at display))
4 NR: Owen,
5 (0.6)
6 NR: One [ninedy eight.
7 [(PT steps off scale)]
8 (0.4)
9 PT: [One ninedy eight?
10 NR: [eh heh!
11 NR: One ninedy eight.
12 PT: Wo:::w.
13 (.]
14 PT: One ninety eight?
15 NR: Yeijah. Sit do:wn.
16 PT: My clothes on.Right?
17 (0.6)
18 PT: (What/Well) is five pounds less¿ Prolly¿
19 (1.9)
20 PT: [(Huh?]
21 NR: [Five pounds less¿I’ll take two,
22 PT: Two?
23 NR: hhh! hh [hh
24 PT: [nhh! hm (.hh)
25 NR: .hh (. OKa::y, I- I need ‘ja tih take this off:,
26 ((NR points to PT’s sweatshirt, preparing him for blood pressure measurement))
NR summons PT by first name at line 4, implicitly re-issuing her prior direction. When PT does not respond immediately (note the delay at line 5), NR announces his weight result, showing that she understands PT's delay in disembarking from the scale as due to trouble seeing his weight result. As NR delivers this result, PT starts to step off the scale (line 7). Although PT physically cooperates with NR's move to close, he interactionally resists closure starting at line 9 by delivering post-result talk. From lines 9 through 14, PT indexes his trouble “believing” the result NR has announced. At line 15, NR once again moves to close the weighing interaction by directing PT into position for the next sign measurement.

As PT starts to sit down, however, he moves to expand the post-result slot further (line 16), securing NR’s co-participation in a mock negotiation at line 21. PT retroactively accounts for his weight being higher-than-expected by attributing five pounds of it to his clothes. Treating PT’s utterance at line 18 as a first offer in a negotiation, NR responds by first challenging PT’s “offer” through her partial repeat “Five pounds less,” and then by presenting him with a counteroffer, “I’ll take two,” (line 21).

Examples 3 through 6 suggest that patients can work to parlay the fact that they are wearing clothing/shoes by attempting to diffuse responsibility for their weights onto these items—items that provide built-in, face-saving accountability during weighing. In fact, patients usually have the option of removing such items pre-weighing but, as seen in Example 4 (lines 5–7), they can decline the opportunity to remove them, subsequently using them as accounts for weight.

In addition to working to preserve an expected weight vis-à-vis a potential or actual discrepant (i.e. “too high”) weight, patients can preemptively work to index that they expect a change in their weights, particularly when that change is tantamount to weight gain. In Examples 7 and 8, patients explicitly state their expectations for weight gain specifically prior and en route to the scale’s display of their weight results.

In Example 7, after PT steps onto the scale (line 3) and NR comments on the just-departed fieldworker (lines 4–7), NR begins manually measuring PT’s weight (line 8). During these sounds of measurement (constituting the measuring/pre-result slot), PT delivers her utterance at lines 9–10.

**Example 7** [33-07]
1 NR: Go ahead an’ s[stand on thuh s[ca#le.the#re.fo#r me.
2 ??: [hh ((door opens))
3 (2.6)/((sounds of beam scale as PT steps onto platform))
4 NR: She jus’ needs a little more (height >thuh</height).=
5 =Poor [thi:#ng¿
6 PT: [Eh- Ye:a[:h,
7 NR: [Go#::sh.
8 (6.7)/((sound of sliding counterweights))
9 PT: °I kno:w I- put on (uh/an) extra se:ven po:unds >in thuh
10 las:tc two months,° ((counterweight sounds))
11 (2.2)/((counterweight sounds))
12 NR: ↑(Right?/>Yer at?<) (about) (0.2) one fifty eight.
13 PT: (Oh.)=Well tha:t’s ten pounds.hh! [hih heh heh heh
14 NR: [ah hah hah hah
15 PT: .hh A few mo[re pounds than you thou↑ght then.hu:h,=
16 [h h h h! [e:a:h?
17 NR: uhih hihih

PT announces that she knows she “put on (uh/an) extra se:ven po:unds >in thuh las:tc two months:” specifically prior and en route to NR finding her numerical weight result at line 12. PT designs this utterance to highlight her pre-existing, independent knowledge and self-monitoring awareness (including “I kno:w” and the specific time frame “> in thuh las:tc two months”), her agency in her own weight gain (“I- put on’’) and her orientation to her weight gain as a recent and temporary deviation from her still-relevant normative weight (modifying “se:ven po:unds” with “extra”).

In Example 8, after PT steps onto the beam scale at line 1, he waits for NR to adjust the counterweights. The video shows NR preparing a thermometer at lines 1–2 such that PT delivers his utterance at line 2 and launches his utterance at line 4 during the pre-measuring slot.
At line 2, PT predicts a general direction of change in his weight, to which he appends an account for the anticipated gain: “Red lobster an’ shit.”¹⁴ His account differs from those deployed by patients in previous exemplars; whereas the patients in Examples 3 through 6 deliver accounts that diffuse responsibility for their weights onto clothes/shoes, PT’s account in Example 8 claims responsibility, attributing his expected weight gain to his chosen eating habits.

All of the examples, however, show patients designing their talk to preserve their images of self (Goffman, 1967) when publicly confronted with their weight results. Their utterances mitigate the potentially face-threatening interactional situation of discovering that they weigh more than they expect in front of another. By preemptively portending change, the patients in Examples 7 and 8 work to present themselves to nurses as the type of persons—who though unable to prevent the forecasted weight gain—are nevertheless independently cognizant of the change. These patients thus show themselves to be proper monitors of their bodies and states of health (cf. Halkowski, in press; Pomerantz & Rintel, 2004).

These findings provide evidence that patients can orient to a systematic preference for prior self-knowledge, working to claim or demonstrate to nurses that they know about their own weights independently of nurses finding and recording them. (This preference sheds additional analytic light on the interactional work patients are doing by announcing predictions for their weights, as in Examples 2, 3, 7 and 8.) The data suggest that being a patient publicly perceived to “not know” about one’s own weight is more potentially problematic (face-threatening) than “knowing in advance” and “being responsible.”

The foregoing data and analysis have shown patients doing work during weighing to manage both the presentation of self-as-patient and the preservation of self-as-person. There is a complementary and overlapping type of interactional work that co-participants do during weighing: that of negotiating¹⁵ how they relate to one another.

Weighing as a locus of (potential) affiliation

That patients treat weight as a moral, volitional and/or accountable sign occasioning face-work (as evidenced by previous examples) suggests that, during weighing, patients orient to themselves as unique “individuals” or “persons,” and not as “routine cases” (Drew & Heritage, 1992). By delivering expansive utterances beyond that required for weight measurement, patients can display their experience of weighing as personal, potentially implicating their identities as “patients” and “persons.” Nurses, however, treat weighing as part of their standardized routine with every patient. As part of doing “professional cautiousness” or “neutrality” (Drew & Heritage, 1992), nurses display a “matter-of-fact

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¹⁴“Red Lobster” is a casual seafood restaurant chain in the US.

¹⁵Such negotiation is accomplished explicitly and implicitly using an array of interactional resources (including talk, gaze, gesture and prosody). Even in cases when co-participants choose to keep their weighing interactions strictly task-focused (see Example A, Note 9 above), this is still an interactional achievement resulting from continuous negotiation of how they are relating to one another.
stance” (Emerson, 1970) during weighing, implicitly conveying that, for their purposes (recording weight results in patients’ charts) and from their perspective, the experience of weighing is medical. Such a medical orientation disattends the “connection” between a patient’s weight and a patient’s self (cf. Emerson, 1970).

There are reasons for parties to co-construct their weighing interaction as standardized, creating and maintaining some relational distance. Socially constituting patients and their weights as “routine” and “medical” may work to neutralize/detoxify or at least diffuse an interactional situation patients can—and recurrently do—treat as personal, moral and thus potentially (face-)threatening. By treating patient weight as medical-not-moral, parties may minimize the “threat” to patients of having to stand up on the raised, stage-like platform of the scale so their weights—vernacularly regarded as private or “intimate” (cf. Henslin & Biggs, 1971)—can become public and official.

On the other hand, there are also reasons for co-participants to jointly produce a personalized weighing interaction. Previous research suggests that medical personnel may more readily gain patients’ cooperation by acknowledging them as “persons” (Emerson, 1970), and that patients’ “feelings” (gleaned through surveys) that medical staff care about them as “persons” may improve patients’ satisfaction with staff and their likelihood of recommending them to others (DeBehnke & Decker, 2002). Thus, it may be beneficial for nurses and patients to “come closer” (cf. Haakana, 2002) interactionally during weighing, relating to one another as “persons”, rather than strictly as “institutional representatives” and “routine cases.”

One way parties can negotiate a balance between personalization and standardization is by delivering utterances that work to invite their recipients to co-expand the weighing interaction with talk/non-lexical sounds that transcend that required for weight measurement. Through these invitations, speakers can proffer an interactional opportunity for affiliation between themselves and their recipients. As shown in the data below, through the acceptance or declination of these invitations, the parties work out “who” they “are” to and for one another and, correlatively, what “type” of encounter—personalized or standardized—they are having with one another.16

In Example 9, PT delivers such an invitation to NR near the beginning of their interaction.

Example 9 [19-02]

1 NR: .hhh! (Go ‘head an’) stand o[n thuh scale.= ([PT lifts 1st foot onto scale])
2 =((sound of scale taking PT’s weight))
3 (1.0)/((PT brings 2nd foot onto scale))
4 PT: [.nh mhhh
5 }((NR gazes at scale display))
6 PT: O[kay. (0.4)
7 }((NR gazes at chart))
8 PT: [>Buh- wha- uh- thu<- What’s thuh=
9 }((NR gazes at scale))
10 PT: =limit?=”Come o::n.Stay [do::wn."=
11 }((NR gazes at chart))
12 NR: =hhh! ↑hih hih huh .hh [Okay. (NR writes in chart))
13 PT: [heh heh hih
14 }((NR gazes at chart))
15 NR: U:::m, (.) S:traight ahead for now.
16 }((PT steps off scale))

At line 7, the video shows PT gazing down at the scale display, saying “Okay.” to mark the moment at which the floor scale has started settling upon a numerical result. After having trouble starting his second turn-constructional unit (TCU) (Sacks, Schegloff & Jefferson, 1974) at line 9, he asks NR a mock question about the scale (“What’s thuh limit?”) as if to self-deprecate by suggesting that his weight is very near the scale’s upper limit. PT then rushes through a transition-relevance place (Sacks et al., 1974), securing a next TCU to cajole the scale (and his weight) in a quieter, coach-like tone of voice, “‘Come o::n.Stay do::wn.” PT’s utterance proffers his desire for a lower weight as an “empathizable” or “relatable”, inviting NR to relate or affiliate with his utterance. At line 13, NR accepts PT’s invitation by laughing immediately (latched to the end of PT’s prior utterance), and just as NR’s laughter decays, PT produces his own laugh tokens to further mark his previous utterance as non-serious, validating NR’s uptake of his

16 “Who” the co-participants “are” to and for one another is, of course, something they co-construct on a moment-by-moment basis through an array of interactional resources (e.g. utterances/body-behaviors). The utterance-based invitations to co-expand and affiliate examined herein are but one part of this larger project. Moreover, the “type” of relationship parties achieve is not restricted to one of two dichotomous poles (personalized or standardized), but can be interactionally situated at any “point” along a standardized-personalized continuum, the “point” itself also being continuously achieved by co-participants.
talk. Their reciprocal laughter indexes their joint orientation to being aligned in momentary affiliation or rapport (Glenn, 1995).

In Example 10, it is the nurse who delivers an invitation to affiliate. During the 17-second silence at line 1, the video shows NR leading PT through a hallway. Just as they near their destination exam room, NR delivers her utterances at lines 2 and 4, directing PT to off-load the items she is carrying before she steps onto the beam scale.

Example 10 [16-01]

1 (17.0)/((PT and NR walking))
2 NR: °(Ju:s') ° put shyour things down before °(you have your:)
3 PT: Sure.
4 NR: =Weight record.
5 PT: OKay,
6 NR: Drop a few pounds.hh hu[h]! hh
7 PT: [hh hih hih Believe me.

NR’s utterance at lines 2 and 4 is specifically oriented to accomplishing weight measurement, and PT complies with it as such at lines 3 and 5. By going on to deliver her utterance at line 6, however, NR is specifically expanding this part of the weighing task with talk and subsequently laughter that together go beyond that required to do weighing. NR’s utterance at line 6 works reflexively to both offer affiliation with PT and invite PT to co-expand and thereby affiliate with NR, referencing a consequence of shedding carryables that NR treats as transparently desirable, and inviting PT to laugh via NR’s own post-completion laugh tokens (Haakana, 2002; Jefferson, 1979; Jefferson, Sacks & Schegloff, 1987). NR is proffering “dropping a few pounds” as a “relatable”, something over which she and PT can relate or affiliate. At line 7, PT accepts NR’s invitation to co-expand by laughing and delivering an affiliating utterance.

Invitations to affiliate can be declined, however, as evidenced by a re-examination of Example 8. PT repeatedly uses profanity (at lines 4 and 14) and self-flagellating comments as moves toward a more familiar, informal interaction with NR (Jefferson et al., 1987). But NR resists his moves, working to preserve their interaction as a standardized encounter by declining each of his invitations, averting her gaze from him when she has an opportunity to make eye contact and staying resolutely on-task, responding (minimally, her mouth closed) only to his utterance (at line 12) that specifically and normatively requires a response.

As seen in Examples 9 and 10, invitation acceptance can be done with laughter. Example 11 shows how acceptance can also be done with other non-lexical sounds.

Example 11 [33-05]

1 (1.8)/((PT steps onto beam scale))
2 PT: You >migh’ as well< put it >at a< hundre[d an’ fifty.
3 [((sound of sliding counterweights))
4 5 NR: ptch! One fifty?=((Alright.)
6 PT: [Ye:ah.
7 PT: hhuh! hm hm hm .nhh
8 (1.0)
9 PT: I would like it tih go under but I just (1.4)
10 NR: ↑U:h about fifty three.
11 PT: Huho::#:[: : :wah?hh
12 NR: [Mho::wuh?hih hih [heh heh heh=
13 PT: [tch!
14 NR: .hh Now be careful.comin’ off a there.

PT uses her utterance at line 2 to accomplish two different actions: she is providing NR with relevant, useful information about a starting point for the counterweights, and she is also intoning her utterance to connote acquiescence, preemptively admitting defeat in her “battle” with her weight. At line 5, NR orients to the former action only. After answering NR’s confirmation check at line 6, PT laughs, inviting NR to also attend to the admitting-defeat action implicated by her talk at line 2.

The silence at line 8 hearably belongs to NR inasmuch as NR is declining to respond to PT’s inviting laughter17 at line 7, and thus is declining to accept PT’s invitation. At line 9, PT elaborates her first utterance and accounts for her

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17Speakers may invite laughter from their recipients by beginning to laugh themselves (Haakana, 2002; Jefferson, 1979).
preceding laughter, making her frustrated desire regarding her weight explicit. She trails off at the end of line 9, and during the silence NR continues to measure her weight, the result of which NR announces at line 10 (omitting mention of the first digit).

At line 11, PT starts to produce a non-lexical extended whine, a “response cry” (Goffman, 1978) that works to index the complainability of the weight result and proffer it as an “empathizable”, thereby once again inviting NR to co-expand and affiliate. At line 12, NR produces her own whine, working to mimic the sound PT is making in overlap as a means of accepting her invitation, claiming to empathize with PT (cf. Heritage, 2004), thereby affiliating with PT. NR uses her mock whine as a way of co-complaining and commiserating with PT. Through this achieved whine synchrony, NR collaborates with PT’s move to personalize this part of their interaction.

Speakers can deploy utterances that, while still transcending the talk required to accomplish the task of weight measurement, work to hedge their “bets” that their recipients will accept their invitations to affiliate and co-expand. Such utterances, or “out-louds” are done responsive to invocations of the scale, produced such that they are hearable as being said primarily to oneself, while simultaneously being audible to co-present others who may (or may not) subsequently treat them as implicating further talk.

In Examples 12 and 13, patients deliver such out-louds while doing “getting ready” to step onto the scales.

Example 12 [20-01]
1 NR: Lemme getcha right on top a that scale please.
2 PT: .hh!
3 (0.5)
4 PT: O:h my God. hm hm hm ((PT puts carryables on floor; NR stands behind PT, waiting for PT to get ready to walk to scale))
5 (3.0)/((PT removes glasses, sweater and scarf))
6 NR: Is that an oh my god a *go:od thing?=or a _ bad thing.
7 ((NR starts walking toward scale))
8 (0.3)/((PT finishes placing carryables on floor))
9 PT: Well I thi:nk I ga
10 (nished weight. ((PT follows NR))
11 NR: Oh(h).
12 PT: huh ho:h
13 (4.8)/((PT removes shoes; NR finds page in chart))
14 (0.8)/((PT steps onto floor scale platform))

Example 13 [14-03]
1 NR: Okay. Can you go ahead an’ sta[nd on thuh scale=)
2 PT: (((PT stands up))
3 PT: =’Oh:h my Go(hh)d.Thuh sc(hh)ale.
4 (1.5)/((PT walks to beam scale))
5 PT: Thuh moment of truth.
6 (0.4)/((PT steps onto scale; NR smiles))
7 (3.8)/((PT slides counterweights))
8 (0.7)/((PT suspends hands in air over counterweights))
9 PT: °(Uh) two¿
10 (1.3)
11 PT: (Add/An’/Uh) forty o::[n:e an’ three quarters?[tih that¿)
12 NR: (((NR steps back)) °(Okay.)

18Gaze direction also helps display these out-louds as hedged invitations; in Examples 12 and 13, both patients gaze away from the nurses while talking, thus choosing not to explicitly address their talk to them (cf. Lerner, 2003).
19Unlike the preceding examples in which invitations to co-expand weighing are done as initiating actions, these out-louds are done as responsive actions; thus, while a recipient can treat out-louds as implicating further talk, such turns do not necessarily project the relevance of a type-matched response (cf. Schegloff, 1995; Lerner, 2003).
These two exemplars show patients using “Oh my God”-type out-louds to do “bracing for impact” vis-a` -vis nurses. In Example 12, PT’s initial reaction to NR’s invocation of the scale is to gasp (line 2), which, after a silence, she follows with “O:h my God.” PT appends post-completion laugh tokens to her out-loud at line 4, retroactively displaying her own stance toward her prior actions and working to invite NR to laugh with her over how she has just publicly “braced for impact.” During the silence at line 6, the video shows NR standing behind PT, waiting for her to do “getting ready” to stand on the scale. (NR may also be waiting to see if PT continues her talk by providing an account for why she has done “bracing for impact.”) Seeing that PT is still actively engaged in getting ready, NR treats PT’s utterance as implicating further talk by launching her utterance at line 7. By delivering this uptake of PT’s out-loud three seconds after PT’s laughter, however, NR’s uptake is hearably delayed; indeed, PT’s position relative to the scale (at line 7, PT is several steps away) and her state of readiness to step up (PT is still getting ready) seem to figure in NR’s choice to accept PT’s invitation to co-expand, for PT’s lack of readiness provides a lull in NR’s task-oriented actions. Although delayed, NR’s other-attentive uptake still accepts PT’s hedged invitation to co-expand weighing.

In Example 13, however, NR chooses to decline PT’s hedged invitation to co-expand, doing only a closed-mouth smile (seen on the video at line 6). NR’s smile displays that she acknowledges PT’s previous out-loud but is choosing to not “join in” (cf.Haakana, 2002). Since NR is standing behind PT, however, it is likely PT does not see her smile. Nevertheless, by smirking even a little, NR displays her understanding of PT’s out-loud as an invitation to do something (i.e., smile, laugh or otherwise affiliate).

During weighing, co-participants deliver invitations to co-expand and affiliate—via out-loud or full-fledged utterance—to do a certain type of work: to gauge “who” they “are” to and for one another. The results of this work shape the “type” of encounter they have. Recipients of invitations can choose to decline them, resisting their interlocutor’s move toward sociability and instead working to preserve their interaction as a relatively standardized encounter. In such cases, nurses and patients relate to each other as institutional representatives and routine cases, respectively. Alternatively, by choosing to accept such invitations, recipients collaborate with their interlocutor’s move to personalize their interaction. In such cases, nurses and patients may relate to each other as “persons” who share common orientations, allowing their interactions to be characterized by a greater degree of sociability, informality and familiarity.

Discussion

Analysis of parties’ weighing conduct has shown that even during a task that is accomplishable within a matter of seconds, nurses and patients do significant interactional work. Parties recurrently opt to deliver expansive utterances during weighing through which they manage how they relate to one another epistemically and experientially.

Confronting their numerical weights in a social/medical setting, patients can work to claim or demonstrate that they possess pre-existing knowledge regarding weight, asserting independent expertise vis-à-vis nurses and claiming result co-recipiency and co-ownership. Patients thereby show “interest” in their weights, displaying that they understand how to interpret results-just-found via comparison to their own previously established normative weights, often treating results as volitional, moral and/or accountable. Through their expansive utterances, patients can contextualize their weights by situating results within an ongoing biography or “lifeworld” (Mishler, 1984), presenting themselves as monitors of their health over time (cf. Pomerantz & Rintel, 2004; Stivers & Heritage, 2001). Co-participants can also use their expansive utterances to proffer an interactional opportunity for affiliation, inviting their recipients to collaborate, if even momentarily, in producing a more personalized weighing interaction.

During weighing in primary-care nurse–patient encounters, co-participants actively choose, on a moment-by-moment basis, how they relate to one another, choices that may prove socially and medically consequential beyond the bounds of weighing.

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