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Dr. Mom? Conversational Play and the Submergence of Professional Status in Childbirth

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Abstract. Through a close analysis of various moments within two hours of video-taped interaction, we investigate properties of the setting that the participants cannot ignore even as they transform them in various ways. These properties are not under local control. What is under control is revealed in the participants' "play" with the properties, including dangerous, "deep" play. In this process, some properties of the participants are rarely mentioned (e.g., that the laboring woman is an MD), others are repeatedly emphasized (e.g. the strength of contractions). And others appear in ways that have not been dealt with adequately in current theoretical frameworks. To deal with life-threatening lies, and jokes about lies, we must move away from theories of hegemonic particularity that rely on a *habitus*. Rather we must acknowledge the practical understandings revealed in the collective submergence of that which may be actively noted as potentially relevant and then set aside so that other tasks can be foregrounded and achieved.

Key words: childbirth, conversation analysis, ethnomethodology, medical interaction, play

> It is the working of the phenomenon that exhibits among its other details the population that staffs it (Garfinkel, 2002: 93).

There are many good reasons to look at this image (Figure 1) as a representation of a familiar scene, Hospital Labor in the late 20th century play: "The birth of a child."

This scene might be summarized briefly in terms of its actors (three men and three women), dramatis personae (obstetrician, anesthesiologist, husband, father, researcher, mother, and, of course, laboring woman),[1] dramatic tension ("are the child and mother going to be alright?"), particular well-scripted moments (the Contraction,[2] the Medical Examination), and also many other interstitial moments when a lot else can happen. In Figure 1, five actors perform one of these moments when obstetrician and nurse prepare to give the woman in labor an internal examination, while anesthesiologist, husband, and researcher back off. Most people who have experienced the world of late 20th century medicine, directly as patients, or indirectly from the media, will recognize the play and the scene and not notice much that is surprising about it. And yet the scene is, also, unique.

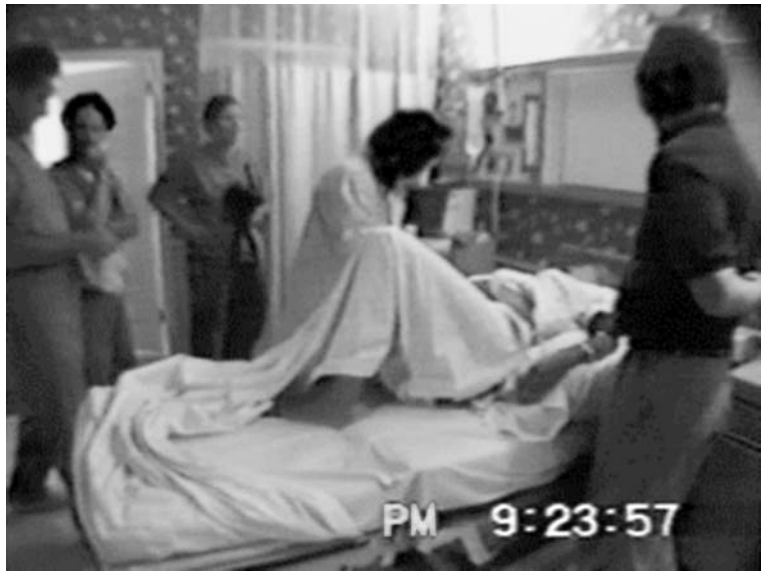

Figure 1. The birth of an American child.

The familiarity that strangers may have with apparently private moments must remain a major theoretical issue for social theory. This easy familiarity is the strongest argument for the sense that concerted action, however emergent, conserves historically developed patterns. The possibility for surprises within such patterns cannot be ignored either. Our goal here is to contribute to the literature that faces both conservation *and* change, or, as these concerns are often named, reproduction *and* agency. Our contribution develops various challenges to theories of conservation that hypothesize that the social order proceeds through internalization and loss of consciousness of oppressing constraints. We disagree with Pierre Bourdieu when he writes that "history" is "forgotten" in and through practice (1980/1990: 56). With Michel de Certeau, Harold Garfinkel, and others, we focus on evidence of practical awareness. In this paper[3] we show that, in practice, participants use certain aspects of the historical constitution of their setting in various attempts to change each other, and, to some extent at least, the patterning of the scene they are producing. This collective work, among other things, reveals to observers what the most immediately consequential matters in any setting are. This work provides the most direct evidence for any argument about the power of aspects of the setting to shape, repeatedly, the setting itself, and all other settings that will appear "like" it precisely because the same aspects will have to be dealt with. The collective work of the participants *also* reveals that they *play*, sometimes dangerously, with those aspects of the setting that became consequential. Thus,

the participants reveal the open nature of even the most powerfully scripted scenes within the most dominant of institutions.

These broad theoretical concerns have driven the literature on the history and general sociology of the medicalization of childbirth (Apple, 1990; Apple and Golden, 1997; Eakins, 1986; Davis-Floyd, 1992; Davis-Floyd and Sargent, 1997; Leavitt, 1986; Rapp, 1999; Sargent and Bascope, 1997). They have also driven much discourse analytic research into medical interactions, particularly as it pertains to women patients (Atkinson and Heath, 1981; Drew and Heritage, 1992; Fisher and Todd, 1986; Heath, 1986, 1992; Mishler, 1984). We fear however that, at times, the passionate concern for women has obscured the actual work of individual women in their local contexts-particularly when these contexts are American hospitals. To bring this work out into the open, we need return to the fundamental questions with the new twist required of those who take "practice" seriously: how come such activity as giving birth should appear so familiar when there are so many reasons for its being unique? How can it be so unique when there are such overwhelming constraints to prevent the participants from deviating? As far as we are concerned, there can be no theory of practical action without a theory of external constraints–"immortal" constraints in Garfinkel's striking metaphor (2002: 92). And there can be no theory of constraints without a theory of the work participants perform with and against these constraints. Above all there cannot be any theory that does not pay attention to what participants actually achieve–even when they do not do what observers, analysts, or moralists wish they had done.

In this paper,[4] we seek to address these general questions through a look at various moments within one woman's labor when various matters are brought up for interactional work.[5] As we show, some are immediately submerged (even when they might have made a major difference in the actual progress of the event); others are abundantly acknowledged (even when the extended and perennial conversations about them appear to make little difference). On the one hand there are matters such as the professional status of the laboring woman, or the presence of the researcher with her two cameras. These matters are briefly mentioned in speech, rarely to reappear. On the other hand there are matters such as the strength of contractions, the level of pain experienced, or the amount of anesthetics to administer. These and a few others are continually mentioned–often with apparent anxious urgency, and sometimes not so seriously.

A brief example should clarify what concerns us. The scene is taken from a moment about half an hour after "Lonnie,"[6] the mother-soon-to-be, has been administered an epidural. Throughout her pre-natal obstetrical visits, Lonnie had made repeated requests that an epidural be administered during her labor; her request was reiterated, and granted. The scene itself occurred approximately an hour before the baby was born (though of course no one knows that for sure at this moment). Lonnie's husband, the nurse, and the

researcher are in the room, hovering over Lonnie. The transcript starts during this contraction and continues for a few seconds thereafter. Figure 2 is a frame grab from the videotape showing a moment towards the end of the contraction when husband, nurse, and researcher check the recording machine.

TRANSCRIPT I[7] (See Appendix B)

Seconds 9:04:58 to 9:05:27

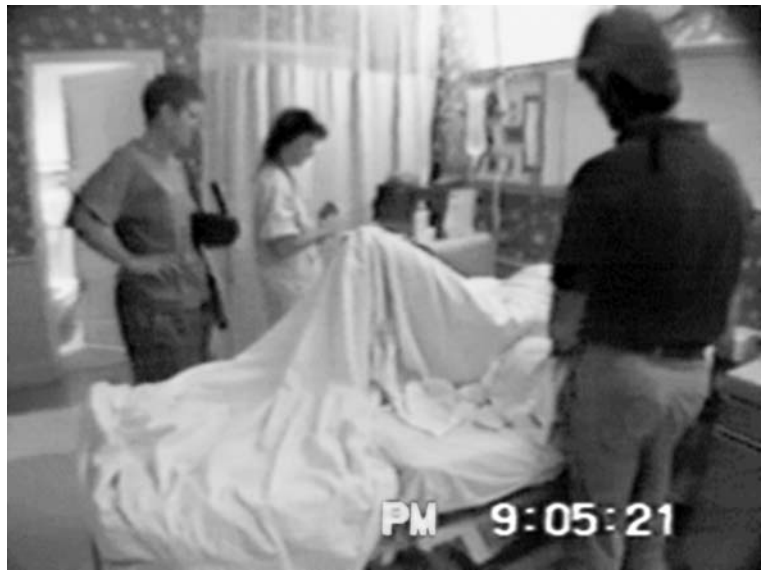

Figure 2. Lonnie is lying on the bed, slowly flexing her left leg; her husband is standing by her side, holding her hand, mostly looking at her and glancing at the contraction monitor; Cotter is standing at the foot of the bed, alternately looking at Lonnie and at the monitor; the nurse is standing in front of the monitor, looking at it, and sometimes glancing at Lonnie.

Note how the contraction is redundantly performed by all the participants in their positioning and movements while holding the positioning. One of these movements involves checking the monitor that is producing a tracing of the strength of the contraction. Technically, all these movements, and pronominal usage in the co-occurring speech, index and constitute that which is happening. "It," interestingly, is not named. "It" is treated as obvious. Something else emerges in speech, and that is the identification of the contraction on a series of axes: on/off, strong/weak, and, most interesting, (not) painful.[8] These contestable identifications are made possible by one salient aspect of the setting: the contraction monitor. It stands here for the ensemble of the medical technologies and procedures that remain in the background at this

particular moment but emerge at other times. Brigitte Jordan (1992) has made the strong argument that these technologies radically limit the authority of women on their own laboring bodies. She appears to have missed, however, that the same technologies can expand the authority of other, non-medical, participants–most saliently here the husband who comments on the contraction and the pain Lonnie may or may not be feeling.

Whether or not the husband "should" claim this authority, it is acknowledged by Lonnie and all the other participants, as they themselves claim various forms of authority during the continuing discussions about Lonnie's pain. Over the course of the labor all in the room produce and challenge accounts of the pain Lonnie is experiencing in relation to the pain she would have to suffer to warrant her reiterated claim that the epidural is not working as it should, and so that she should be given more medication. These accounts include direct reference to a wide range of matters (the monitor, the skill of the anesthesiologist, the history of Lonnie's earlier labors, etc.). They reveal practical understandings and productive use of technologies and procedures that are often presented as so overwhelming as to disappear from awareness. Our own sense is that the very power of the technologies requires practical action, and perhaps indeed a heightened awareness. The technologies constrain possibilities, but they also are resources for further transformation of the setting. They can be joked about and even played with, dangerously. The accounts also reveal how people establish themselves as *participants* who may claim the authority to transform.

Through all this, the participants, eventually, constitute differentiated positions for each other to occupy. One of these positions is precisely that of the laboring woman-who-is-worrying-about-the-pain-she-is-experiencing. This position all but submerges other positions that are mentioned briefly, but rarely with any acknowledged consequences. There are, among others, the position of experienced-mother (this is Lonnie's third child) and, most interesting, her position as a medical doctor. This status emerges a few times and we briefly analyze the one moment when this status appears to make a specific difference in the local production of this labor. By contrast, her status as suffering body and as interpreter of pain is redundantly acknowledged both through acceptance *and* through challenge. To put it starkly, in this delivery room, there are up to three MDs (Lonnie, the obstetrician, and the anesthesiologist–see Figure 1) and never less than one (Lonnie); but there is actually never more than one acting *as* doctor–and that one is *never* Lonnie.[9]

Note that we never seek to determine whether emergence and submergence is an intentional matter in any of the participants' mind–whatever their authority or power within the setting. Any of the participants may have wished for other matters to emerge or be submerged. What we, as observers, can only report upon is what was *publicly* acknowledged by the collectivity. In the process of emergence and submergence, the participants locally and collectively

reconstitute an event that is easy to recognize: the successfully unproblematic labor of a middle class mother in a good hospital of the late 20th century United States. But the fact that such a reconstitution took place should not prevent us from recognizing the continuous "labor" of the participants, their uncertainty about what is to happen next, the deliberate feedback they continually give each other, the resources that are available to them locally, and the limits and opportunities provided by these resources.

After a brief account of what first alerted us to the constitution of certain matters as inconsequential for this labor, the paper proceeds to a summary of various times when the core processes are at work. First, we look at "ordinary times," the features of which constitute the taken-for-granted frame of the event as Hospital Labor: Contraction and Medical Examination. At these times what is to remain open for variation is tightly scripted. Second, we look at what we will refer to as "*et cetera* times" to index the multiplicity of matters that can be brought out while all wait for the next contraction or examination: the children under the care of the grandmother, the research, the marital status of the anesthesiologist, Lonnie's earlier labors, and so on and so forth. We are very interested in these times because they also provide openings for the most "ordinary" matters to be brought back in unscripted ways. Then, the extraordinary may happen around the matters that are always at stake in labor pain, and through pain, life and death.

Audience Reaction to Research

People who first see the video record do not immediately guess Lonnie's status as a medical doctor. In our experience, audiences, mostly adult students in a leading school of education, often professional women (in education, health, and psychological services), many of them mothers and quite a few nurses, take but a few seconds to accept that they are indeed watching a hospital labor and there are few "errors" identifying the major dramatis personae (attending physicians and nurses, husband, researcher). It is also common for casual observers to become quite sure that the laboring woman is a white, probably affluent, suburbanite. But few are those who pick up on the minor details that could be used to guess her professional status.[10] Neither do they pick up on details possibly pointing at the husband's profession, or at the obstetrician's marital status. It is as if the total setup of the recorded image as constructed by the participants and the camera conspired to hide much that did not fit within the local patterns for what was to emerge in public speech.

Things become more complicated when the same audience is told that Lonnie is a physician. Then, casual observers cannot be shaken from the certainty that everything they see is the result of this status, thus invalidating the research as in any way relevant to "normal" childbirth in an American

hospital: Being a doctor *must* make a difference even if one cannot specify observationally what this difference is making. That it might make no difference, or that it should lead at most to minor ripples in the progression of the labor, ripples that are immediately discounted interactionally, is a major scandal to a general audience. That the woman herself should appear to participate directly in the erasure of her status is even more scandalous. "In this day and age," many like to say, a professional woman should not let herself be placed in the helpless position of the scared, ignorant, dependent woman when apparently everything is set for her to claim a leading role in the control of her own body.

Practically, casual viewers are making a methodological challenge: Lonnie's case is not "typical" or "representative," and the research is thus not useful. To this concern we answer that we do not claim the case is typical. We claim it is *instructive* in revealing constraints all women must experience in one way or another. It is the case that Lonnie appeared quite satisfied with the way she was treated by the hospital personnel during her labor while many women leave quite dissatistified. It may also be the case that the medical personnel "respected her knowledge" more than they may respect the knowledge of other, non-professional women. But there is no evidence that the special features of this case changed the structural features that differentiate forms of knowledge in interaction, as well as privilege some forms. We remain struck by the extent to which this labor exhibits all the features that have been identified in other research on labor and delivery, as well as on medical interaction in general.

Practically, casual viewers also challenge Lonnie herself from a moral or political point of view. Many find it outrageous that a professional woman should be just as much at the mercy of the medical establishment as any one else. It *cannot* be so, and we, as researchers, may have missed how Lonnie is getting preferential treatment. But, above all, it *should not* be so. The theoretical interest of this reaction lies in what it reveals of the ambivalence of many women about a most routine social event and should thus challenge any consensus theory of culture. Labor and delivery may be some of the most "cultural" events of human life, in that they are a moment of fundamental human concern requiring a heightened sense of the need to transform the natural into the human.[11] But they certainly are in Euro-American cultures–as they must be everywhere–a site of uncertainty, contestation, and ideological struggle. It must be so locally, as the pregnant woman and her immediately significant others constitute for each other the unique labor that, they must always fear, could turn out badly. It must be so more broadly, among medical researchers, hospital administrators, and all others involved in designing and implementing new policies for all to follow–until history reveals their limitations. Contestation of constituted distinctions is at the heart of culture–not consensus.

We now proceed with a close look at one set of people as they make one unique hospital labor, constitute their statuses for the duration using much that they cannot escape, and play with one of those matters. We start with a summary of some features of "ordinary times" when the participants go through their motions.

Ordinary Times: Scripts, Openings and Consequences

Scripts

While the video-taped labor can be considered to be one event–Hospital Labor–it is powerfully organized by two sets of scenes that segment it into marked and unmarked times. At regular intervals all involved perform "The Contraction." At less regular intervals, all perform "The Medical Examination." There is very little ambiguity about the onsets and endings of the marked times as one can clearly see all participants reposition themselves to apparently appointed places.[12] This reorganization is both a physical event (as bodies move) and a discourse event (as the pattern for who-can-speak-about-what shifts).

The Contraction (Figure 2) starts with some brief: display a groan and/or grimace) expanded into a request by Lonnie that her hands be held–by her husband most often, but also by the researcher, and once or twice by the nurse. She holds hands for the duration while the other participants focus on her; they tell her to breathe and, more and more often as the labor progresses, they give her reports on the strength of the contraction and the likely moment of its end.

The Medical Examination (Figure 1) starts with a moment of chitchat between the doctor who is to conduct the examination and Lonnie as he enters the room (and after he has glanced at the monitor), followed by a brief explanation of what is to be done, followed by the procedure itself, and ending with a brief report. During that time the focus of all talk is on the doctor. All other participants (including doctors who are not authoritative at the moment) move back both in their physical positioning and their talk.[13]

We refer to these models of the many single instances of each event as "canonical"[14] to index that they are not to be taken as "patterns" in any simple sense. The above summaries are not "averages." Neither are they quite "what happens when nothing else happens," repetitively or mechanistically. Rather they are what people explicitly hold each other accountable for, particularly when something else is happening, which is almost always the case. Indeed

one could say that most of the talk and movement performed by the people over the course of the labor consists of stage directions or justifications for behavior thereby made visible. In culture, we argue, people do not follow rules. Rather they continually tell others what rules they should have followed. The most visible of these stage directions is repeatedly performed by Lonnie as she specifically calls on her husband to come and hold her hand. Quite often he is not "right there" when interactional space is opened for the contraction, and she specifically reminds him of his obligations as she moves her hands. Elsewhere Cotter (1996) has written of such moments as "negotiations" to stress the relative uncertainty of all the participants about what is happening or is going to happen. Here, we write of "authoritative reconstitution" to stress the extent to which people tell each other what to do next, and the extent to which they often appear to do what they are asked to do. Regularly, Lonnie asks her husband to hold her hand at the beginning of a contraction. Regularly, he complies. These are matters that become visible in talk. Other matters, for example the overall frame for the scene in its canonical form, are not of particular concern. The form is *not* the subject of negotiations or stage direction: it is unchallenged in the very local interactional work that it allows and, indeed, requires.[15]

This interactional work is what concerns us here. Giving birth is not simply a biological process. Contractions are not only physical events in that process. Giving birth, as a total event in any human setting, is a social event during which the participants use various cues from the laboring body as they are made public–whether by the woman or, in a contemporary hospital, by various machines. The centrality of the contraction monitor in this labor is also a cue that giving birth is a cultural event during which further patterns are at play with ever more complex consequences for the individual participants. For example, in this labor, the physical contraction was, on occasion, overridden by the Medical Examination, and failed to become an interactional event. This suggests that the two events, Contraction and Medical Examination, are closely linked in a hierarchical relationship where all matters medical, from doctors to monitors, will always trump the *et cetera* aspects of contractions (just as contractions trump other matters that non-medical participants can bring up between contractions).

Openings for Improvisation

All contractions, in the detail of the performances of the participants, differ. Each is unique, and our task is also to bring out what allows for the uniqueness. The same things can be said of medical examinations. Canonical forms are not sets of programmed commands; they are also open for alternative routes to routine completion. Exploring these in any detail would take us too far afield. We focus on only one moment when we can notice how these openings

can operate. Transcript II is of a sub-sequence during a medical examination when the doctor explains the procedure to come. In this case the procedure can be performed in two different ways and the doctor appears to yield to the patient's choice.

TRANSCRIPT II (see Appendix C)

Seconds 8:26:20 to 8:27:05

> [Anesthesiologist enters the room, talks briefly to the nurse, and then turns towards the husband. He leans forward to shake husband's hand as he appears to introduce himself. The anesthesiologist then straightens up, crosses his hand in front of himself as he faces Lonnie and directly addresses her. He keeps this stance until 8:27:10 while he, first, chats with her about her job, second and after a few seconds of silence, explains to her about the epidural procedure, third, agrees to consider an alternative in one detail of the procedure, and, fourth, accepts what is made into a choice. The transcript starts with the second part of the examination]

The sequence about choice reveals the availability of alternatives within a set of possible moves. In this case the alternative is opened by Lonnie. Her raising the issue may have to do with her knowledge, either as someone who has already gone through the procedure at least twice, or because of her medical training. In any event, the anesthesiologist does not mark the request as extraordinary. He gives his preference and then yields to Lonnie's. That things can be done in various ways is thus made part of the routine.

This matter is taken in stride and is not marked as disrupting the labor. So are many other matters. The number of those appears to be indefinitely large in that there appear to be no mechanisms for those who have authority over the organization of hospital labor to prevent these matters being brought out during the many moments when neither Contraction nor Medical Examination are being performed. This openness of Labor to the extent that it is also a temporal activity does not mean that the matters that are addressed do not have to take into account the labor itself. Nor does it mean that these matters cannot make a difference in the labor itself. We return to this at some length after considering one of the major consequences of the canonical form for the participants.

(Possibly Unintended) Consequences of the Medicalization of Childbirth

One of the most fateful aspects of medicalization of childbirth is anesthesia and the consequent development for external forms of monitoring, including mechanical ones. While a world without anesthesia would now seem

unimaginably cruel, it has opened new, and multiple, ways for social interaction around pain. Anesthesia limits pain, but not the concern with pain, and it organizes the details of the social work that is produced around pain.[16] The choice of the position for the administration of the epidural is only a moment in this work. More consequential is whether the result (what the person is experiencing) is close enough to what one might expect. Again, there are many aspects to this. We mention only one: the shifts in the laboring woman's authority to speak about her pain. By all accounts, as the labor progresses and the anesthetic has arguably (and there is much argument about this) taken effect, Lonnie is made to be less and less central as the initiator of the public performance of the Contraction, or as the one who can give the last word about its interpretation. Instead the monitor, or more precisely the readers of the monitor (doctor, nurse, and particularly husband) take it upon themselves to challenge the interpretation of the contraction.

As mentioned, the canonical Contraction provides occasions for talk about pain, given some evidence of the "strength" of the physical contraction. At these times Lonnie is but one of the participants who may speak. She is given a voice but her voice is only one among the many who can discuss her pain, the strength of the contraction and what to do about it, if anything. At these times, Lonnie's body may be the focus of attention but it is not particularly "her" body: she has no privileged right to give it voice. The official arbiter is the monitor as interpreted in terms of the epidural received earlier. "Everyone" (in the formal sense that every one does speak and every one is heard–no one is shut up, no one withdraws from offering interpretations) is entitled to offer a potentially consequential interpretation of the strength of the contraction, the pain involved, and the possible need for more anesthetics. Note that the medical personnel are not given routine deference. No one is given overriding expertise–not even the woman. This contrasts obviously with the medical procedures (including prescribing more pain-killers) which are only performed by the designated specialist.

Et Cetera Times: What is (Not) at Stake During Labor

Both Contraction and Medical Examination contrast, though perhaps less obviously, with the various times when husband and wife (and researcher, nurse, even doctors) deal with family business (as well as any number of other businesses) in a kind of temporary interactional bubble partially constructed by the withdrawal of the medical personnel from an area in which they do not assert authority. After all, even during such a strongly framed scene as a hospital labor, most of the time spent in the delivery room is not spent doing contractions or medical examinations. To ignore such times is precisely to fall victim to the participants' identifications of what they do during these times

as irrelevant. We refer to these times as *et cetera* times to index and expand that aspect of ethnomethodology that has shown that nothing about human interaction can be fully accounted for. It is also the case that no moment, however scripted, can fully disallow the co-occurrent performance of matters that may be only related to the moment to the extent that the performance must take it into account in order to proceed.[17] As analysts, we must pay close attention to embedded *et cetera* times for much may be indexed there more specifically than it is during the more scripted moments. In our case most of the talk that occurs during the times between contractions and examinations addresses what happened in the earlier marked time or what might happen next. This "chitchat," as we refer to it, ranges over a broad, and apparently open, set of topics and activities, from phone calls to the woman's mother to check on the children, to discussion about the research, *"Et Cetera*."

We look at two moments of chitchat. During the first, two matters surface. Each could have made a major local difference but there is little evidence that either did. These matters have to do with the status of Lonnie as an MD and the presence of the researchers. They are brought up for consideration and then dismissed. The second moment of chitchat that we examine indexes an awareness that nothing that is said should be taken quite at face value. It is a bantering exchange about the incompetence of an anesthesiologist and the possibility that Lonnie is lying about the pain she is experiencing. As discussed earlier, casual audiences generally latch on to Lonnie being a doctor, and the labor being observed for research, as evidence that this labor is "unique" or "atypical." Actually, there are many more than these two matters that makes this labor unique. These matters must include the fact that, in an earlier labor, Lonnie had lied to an anesthesiologist and reports this lie in this labor. But to focus solely on the uniqueness of this labor would erase the fact that the lying, and the joking about it, are what reveals this labor as most typical of that which *may always happen* in American hospitals–given the cultural properties of childbirth. Culture is not about reproduction, but about, actively, *making* sense–collectively.

What is not at Stake

In the details of the interactional work in this labor, Lonnie's professional status is only mentioned directly twice, both during chitchat times.[18] Cotter's status as researcher is similarly submerged. She came with two cameras, one fixed and one that she held as she moved around the room. We can see, on the record, participants repeatedly rearranging their bodies to accommodate the cameras and Cotter's filming but the matter is specifically discussed for less than a minute over two or three short segments that always occurred during chitchat. The filming was never marked as an interruption.

In the segment we now look at, Cotter asks for the permission of the anesthesiologist to record him: "is it O.K. with you all if you are on this video

tape?"[19] The "you all" does not really index all the participants (husband, wife, nurse) who have already given their permission and have been taped for more than half-an-hour. Cotter is addressing the anesthesiologist, as the whole group acknowledges by letting him answer. He entered the room three minutes earlier with no prior knowledge that there would be cameras in the room but has not yet specifically addressed the cameras except to ask that one of them be moved as he began the major task of the moment: setting up (with the nurse) for the epidural. In other words, he has not marked the videotaping as an event requiring him to make accountable changes in his routine. During this time, Lonnie moves away from the bed (and off camera) while anesthesiologist and nurse attend to various preparations. Towards the end of the sequence, the bed is performatively declared ready for the epidural–as all move together to their appointed places. The "permission" sequence is nestled within a bed-preparation sub-sequence which is itself a routine part of the epidural-giving sequence. It does not in any way suspend it. It is as if this Medical Procedure fully allowed for a permission sequence to be included within it: the interactional room was there all along for some *et cetera* activity.

TRANSCRIPT III (See Appendix D)

Seconds 8:28:06 to 8:28:39

> [all members are moving about the room; when Cotter starts, the anesthesiologist is searching in a drawer, and then moves on rearranging objects as he says "sure, sure" and then "accomodating her"; the nurse is equally busy at various tasks; the husband moves in and out of the picture in what looks like "getting out of the way"; Lonnie who, at first, is waiting behind the camera, then moves onto the bed and sits on it while the nurse rearranges the drip; the comment "because she is a doctor," said as the anesthesiologist has faced Cotter, appears at a time when the doctor appears to be waiting for the nurse to finish rearranging pillows and sheets]

After the first of Cotter's statements, the anesthesiologist's "sure, sure" (8:28:13) could stand as granting permission. Cotter appears to take this as too cursory or otherwise insufficient as she shifts from a question ("is it OK. . .?", 8:28:07) to a justification ("I know they asked a lot of people . . . but I want to be sure. . .", 8:28:17). The anesthesiologist takes this indeed as a request for the grounds of his permission ("accommodating her . . . because she is a doctor", 8:28:26 and 8:28:33). The stated ground is, of course, of interest since it is one of the very few places where Lonnie's status is specifically addressed and the only place where it appears to be used for making treatment exceptional.

It should first be mentioned that this somewhat off-the-cuff statement by the anesthesiologist does not in any way index the process that led to Cotter's presence in the room with her cameras. The process was quite a personal one in which friendship networks played a definite role. Lonnie and her obstetrician allowed Cotter to follow her and tape throughout her pre-natal visits and the labor on the basis of a somewhat distant acquaintanceship. The anesthesiologist's "because she is a doctor" is followed by general laughter that allows or encourages him to expand in a joking tone "if it were anybody else!" Laughter is always ambiguous but it functions here, as it often does interactionally, as a closing marker. No one picks up the ball as everyone organizes for the administration of the epidural. The central sequence of the Medical Procedure has now started and ordinary time has reasserted itself. All in all, there is very little ground to argue that a "negotiation" took place about giving permission for the research. It may have been Cotter's "intention" to have such a negotiation, and it is possible that the anesthesiologist briefly considered entering into this negotiation: for a moment, both he and the nurse face Cotter (until then they had just proceeded with their tasks). But then he turns away as he (jointly with Lonnie who laughs, her husband, and the nurse) transforms the possible negotiation into an inconsequential, somewhat joking statement. The anesthesiologist's "Because she is a doctor!", performed as it is with a joking intonation, can be taken as a variation on the common response of audiences to presentations of this work. The statement also dismisses it as something that might need to be dealt with. This is in fact how Lonnie's status as an MD is treated through the labor. It is known and mentioned but never put at explicit stake. Something else is: pain and its alleviation through various medical procedures. This is very clearly performed as the permission sub-sequence closes and all bodies organize for the administration of the epidural.

What is at Stake

We are focusing here on a long narrative that occurs more or less in the middle of the labor, almost half an hour after the epidural has been administered and before any signs that the delivery is in sight. The anesthesiologist has come back to check. Lonnie starts with a direct challenge of his estimation that things are as they should be. He challenges her back. And she then launches into a narrative about how, in her preceding labor, she had lied about pain she was not experiencing in order to get a second dosage of epidural, with almost dire consequences. The narrative is presented as a humorous tale and is taken as such by all participants, who laugh in unison with Lonnie at a punch line delivered by anesthesiologist and husband. We are going to quote only the first utterances when Lonnie appears to challenge the anesthesiologist's estimation that everything is fine, and the end of the narrative when all laugh.

TRANSCRIPT IV (See Appendix E)

Seconds 9:18:30 to 9:19:00

[all participants are in the relaxed chitchat position throughout]

The anesthesiologist "does not feel guilty" that Lonnie is still feeling some pain. He counter-challenges her about what she must have gone through during her other labors. She had not been his patient and he must be referring to her charts when he summarized the salient features of these: "the one with the forceps and the one in the O.R." This concludes in general laughter and is followed by a classic opening to a joke's telling (Sacks, 1974): "listen, you want to hear about the C section?" (9:18:58) There are two punch lines to this story. First, the "Chinese" anesthesiologist could not pronounce the 'l' in "clamp" and "kept saying 'give me a cramp'!". Second, Lonnie is identified, with laughter, as "dangerous" after she has told how she put herself at serious risk "I thought I was like, never going to walk again!" (9:19:47). This statement is followed by the general laughter that the tone of the comment invited. Husband and anesthesiologist look at each other and agree laughingly: "She is dangerous!" (see Figure 3). In between the two punch lines, Lonnie and the anesthesiologist perform the telling of the lie as lie:[20] "I kept saying I could feel the alcohol swipe even though I couldn't" (slight paraphrase).

TRANSCRIPT V (See Appendix F)

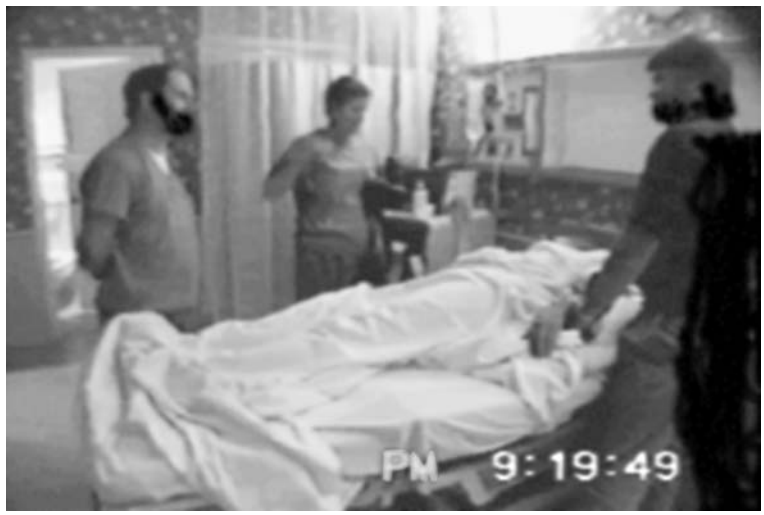

Figure 3. Telling about the lie, punch line, laughter, and coda.

In a coda to this, Lonnie justifies her action by stating that she couldn't trust an anesthesiologist who could not deal with the tubing.

The interpretative difficulty here concerns the sequencing of this story: "why" tell this story to an anesthesiologist at the very moment when an apparent appeal for more pain killer is being made. What is Lonnie stating in this sequence? That she is justified in asking for more (as it appears she is doing at the beginning) or that she is not to be trusted (as she may be doing by not challenging directly the final chorus of "she is dangerous")? All interpretations are possible here, including many with specific interactional consequences: after such a story (that is clearly not a surprise to the husband), any statement by Lonnie about her pain is open to justifiable challenge. If nothing else, the authority of all to participate in interpreting the pain has been reconstituted. Perhaps even more importantly in this context, the final authority of anesthesiologists is fully acknowledged: if they cannot be convinced, then they must be lied to. And if one has doubt about one's own sense, then a warning about one's past may be in order. And a joke can serve as such a warning.

Structure in Play

We did not observe the incident Lonnie recounts about her earlier labor. If her account is even close to what happened, then a reference to Garfinkel's analysis of Agnes's passing is in order (1967/1984). Agnes was born with male genitalia and reported on her continual work from her teenage years onward to convince all around not to notice her as anything other than a woman. Garfinkel talked to her at the time when she was attempting to convince the doctors who would perform the sex-change operation. The issue then was whether she was in fact, and had always been, a "natural" woman. This involved a lot of work on her part that may have included what could be considered a major lie: whether she had taken estrogen to enlarge her breasts or whether they had developed on their own. In the initial probe, those in authority convinced themselves that she had not. Eight years later, in talking with one of the main doctors, "with the greatest casualness, in mid-sentence, and without giving the slightest warning it was coming, she revealed that she had never had a biological defect that had feminised her but that she had been taking estrogens since age 12" (1967/1984, Appendix to Chapter V). Thus Agnes had not only passed as a woman with peers but also with a whole team of doctors and researchers.

Some may think that Agnes' case is an extraordinary one. We think of it as illuminating the work needed to maintain the familiarity of routine events, particularly when the most serious matters are at stake. Lonnie is in a similar position to Agnes. She may be in pain, she may be lying about her pain, and all around her must consider the possibility that she is in pain *and* that she is lying about being in pain. Maybe her claims that she is in pain are a

play, a form of make believe that the others need not take literally. Jordan has shown that the making of such claims, the dismissing of such claims, and the opening of occasions for dangerous lying, are all structurally linked to a system in which the patient does not directly control the dispensing of anesthesia. In all hospitals of the late 20th century, the dispensing proceeds through various persons performing differentiated tasks with specialized authority. But it makes a lot of difference in the details of the social interaction around labor and pain whether the patient has the authority to directly administer to herself pain killers–as she does have in some European countries. In Lonnie's hospital, as in the stereotypical American hospitals of the late 1990s, the set of specific tasks relating to pain involves (for the woman and those siding with her) playing out plausible claims, and (for the medical personel, but also sometimes the husband and the woman herself) sorting out the plausibility of these claims. As Christian Heath argues, "the revelation of pain and its management are interactionally organized" (1989: 122) and this revelation, in medical practice, "places the patient under two almost incompatible demands": the patient must "justify seeking professional help" and "adopt an analytic orientation towards his own 'unpleasant' experiences" (1989: 124). But Heath does not consider that the patient (or the doctor) might be lying–or at least performing the accountably appropriate for ends that might be deemed extremely questionable if they were discovered.

We talk of play here most obviously, perhaps, because Lonnie's tale of the earlier lie was performed collectively as a joke. No one picked up specifically on the darker possibilities, even though it is plausible that at least some of the participants were aware of them. We also talk of play to place our work in the long tradition which, since Shakespeare, through Erving Goffman (1959) and Victor Turner (1974), has developed the idea that routine social interaction has theatrical aspects. If "life is a stage" then we are all indeed actors in a play, making believe to an audience that what they are representing is a reality, and asking the audience to suspend their disbelief. We are particularly interested in settings when this play is actually "deep play" in the sense that Clifford Geertz borrowed from Jeremy Bentham: there are times when, in play, we put our full status on the line (1972/1973).[21] This puts a tragic twist to Gregory Bateson's famous sketch of what is implied by the statement "this is play" (1955/1972). Above all we talk about "play" because it opens new vistas for interactional analyses. In this perpective, it is useful to think of what Lonnie had done in her earlier labor as a form of deep play. In that labor, she placed a distinct bet that her statement about feeling pain she did not actually feel would not jeopardize her own and her child's well-being or even life. Her bet was all the "deeper" in that she is a medical doctor who must know better than others what the dangers of anesthesia can be. Her play could have ended in tragedy. It appears in our data as comedy. In both cases, Lonnie's performance was allowed and organized by the properties of the setting

and procedures. She did not make the conditions. But she made something unique–as everything that is made socially must also always be–particularly perhaps when it can also appear to a casual observer as routine and familiar.

We take playing deeply as a form of "passing" in Garfinkel's definition of "the work of achieving and making secure their rights to live in the elected sex [professional, pain] status while providing for the possibility of detection and ruin carried out within the socially structured conditions in which this work occurred" (1967/1984: 118). The word 'play' allows us also to talk about moments when the most authoritative of the participants may actually be aware of the status put in play but chooses, for whatever reason, not do the work of detection and ruin. The fundamental point is that analysts must accept that, even in the routine of everyday life, human beings may be playing with each other, their conditions, and their fates (Boon, 1999). We think that pursuing this might move us beyond altogether tired theoretical conversations about determination and agency.

In Conclusion

Failing to consider the possibility that patients and doctors do play with each other can also obscure the facticity of the local setting (including institutions, people, and machines) that individuals use, whether or not they play, whether or not they resist. Failing to consider play obscures the historical–that is cultural–constitution of this setting. And it obscures the uncertainty of all participants about the evolving scene. It obscures the work that all, routinely and at times of crises, perform to test limits that are both factual and arbitrary, immortal (that is, for us, far beyond our personal control in our life time) and always not fully developed and yet in decadence. This argument directly builds on earlier research, particularly the work of Ray P. McDermott and Henry Tylbor (1983), on what they talked of as "collusion": local groups "playing together" at evaluating whether a particular child could be said to know how to read. Given that much collusion is indeed done through joking, artistic performance, and other forms, we prefer to confront the possibility that, even when the most serious matters are at stake, human beings will play with possibilities. They will consider alternatives, shortcuts, inconsequential challenges. And they will do this at the local level as well as in the most public of levels. The history of policies about the medicalization of childbirth is a story of many shifts, with various possibilities explored by the different polities who control hospitals. Jordan (1978/1993) shows how the United States, the Netherlands, and Sweden differ. Policy in the United States continues to evolve and there are significant differences among hospitals when State agencies, insurance companies, and others who may set policy, allow for such differences. The

reality of these shifts implies that, as people get together to achieve hopefully well coordinated goals (such as giving birth and routinely working in a hospital as either doctor or nurse), their work will have to take into account their actual conditions and thus look different, or familiar, to onlookers–depending on their own experiences with conditions. In other words, we must recognize in our analyses both that (1) historically constituted conditions are factual–"immortal" in Garfinkel's sense–and that (2) precisely because the social order is external to any local participant, these participants can be expected to do the unexpected. Lying in interaction is not an aberration; it is symptomatic of the conditions of human everyday lives. Garfinkel's Agnes, as a case of "passing," is but an extreme instance of what we all need to do, day in and day out, when gender identifications are made relevant. The medical literature is replete with complaints about "patient non-compliance." Much recent work on schooling documents the extent to which school personnel must ignore what students (do not) know, or what students (do not) do, in order to justify their own decisions about whom to fail/pass (Mehan, 1986; McDermott, 1993; Mullooly and Varenne, 2007; Varenne and McDermott, 1998). All of this work should make it much harder than it has been to argue that people in difficult, if not oppressive situations, are not aware of their conditions and have internalized cultural arbitraries. As one looks more carefully, it is becoming possible to document more and more precisely that dissatisfaction with the social order is something that is routinely displayed, even when doing so puts oneself at serious risk.[22] We would in fact reverse the old functionalist equation between homeostasis and the internalization of the fundamental structuring principles. Being faced with the most difficult moments in lives always conducted fully within complex cultural elaborations, must trigger new forms of challenging practices, dangerous ones as well as playful ones–if the difference between the two can in fact be made.

Appendix A: On the Research, the Taping and the Transcription Conventions Used Here

The original research was conducted in the early 1990s and involved videotaping all pre-natal visits by "Lonnie" (a pseudonym) to her obstetrician, as well as the labor and the first get together of the parents, the new baby and his sibling. All observations and taping were done in full view of the participants who were aware of the research goal and had given their permission according to the standards of the time. The videotapes were transcribed through paraphrases of the combined visual and audio stream at about one minute intervals. Selections were selected for more detailed transcriptions of the recorded interaction. Our first priority in these transcriptions was the representation of three central properties of the event: co-participation of all present, postural

shifts, and semantic content. We decided not to use the usual conventions from conversational analysis as they tend to obscure the active co-participation of participants who may be silent at any particular time (Goodwin, 1981), and do not allow for easy incorporation of visual information that can now be made available through thumbnails of frame grabs. Details about the transcription conventions, and the justification for audio transcription can be found elsewhere (Ochs, 1979; Varenne, 1992). In brief, each line of the transcript represents one second. ". . ." indicates a half second of silence. In the transcripts available on the research web site, one frame grab is included for each 10 seconds. We did not attempt to catch most of the variations in the phonetic aspects of the verbal stream since we are not using these for analysis here. Finally, the sound files will be made available on the web for re-analysis. The research web site is available at: http://varenne.tc.columbia.edu/hv/doc/doc_HS.html.

Appendix B

TRANSCRIPT I
Seconds 9:04:58 to 9:05:27

Time	Wife	Husband	Researcher	Nurse
9:04:58	....	.... breathe	....	....
9:04:59	....	breathe	....	....
9:05:00	....	....	....	....
	....	....	....	....
	....	blow it out	....	....
	....	come on .... keep	....	....
	....	breathing	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	....
9:05:10	....	....	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	it's going down
	....	....	....	now ....
	....	....	....	....
	....	....	....	....
	....	....	....	....
	....	....	....	....

(*Continued on next page*)

(*Continued*)

Time	Wife	Husband	Researcher	Nurse
9:05:20	....	that one	....	....
	....	was almost as spikey as	....	....
	....	the one you have had	....	....
	....	before	....	....
	oh well it hurt	....	....	....
	....	well clearly it didn't	....	....
	....	hurt as much as the other	....	....
	it hurt though		....	....

Appendix C

TRANSCRIPT II

Seconds 8:26:20 to 8:27:05

Time	Wife	Husband	Anesthesiologist	Researcher	Nurse
8:26:20	....	....	....	....	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	Did you have an	....	....
	....	....	epidural the last	....	....
	....	....	time?	....	....
	two times	....	....	....	
	the last two times	....	....	....	....
8:26:30	....	....	....	....	....
	....	....	o.k.	....	....
	....	....	we'll do the same	....	....
	....	....	thing over again	....	....
	....	....	and	....	....
	....	....	we are just going to	....	....
	....	....	put a needle in your	....	....
	....	....	back	....	....
	....	....	we'll put through a	....	....
	....	....	soft plastic catheter	....	....
[A FEW TURNS ABOUT ALLERGIES]					
8:26:56	are you going to do	....	....	....	....
8:26:57	it sitting up?	....	....	....	....
8:26:58	....	....	ah, I prefer lying	....	....
8:26:59	....	....	doing if it's OK	....	....
8:27:00	....	....	with you. I can do it	....	....
	....	....	either way;	....	....
	....	....	whichever way you	....	....
	....	....	feel more	....	....
	....	....	comfortable	....	....
	I prefer sitting up	....	....	....	....

Appendix D

TRANSCRIPT III

Seconds 8:28:06 to 8:28:39

Time	Wife	Husband	Anesthesiologist	Researcher	Nurse
8:28:06	....	....	....	....	....
8:28:07	....	....	....	is it OK with you all if you	....
8:28:08	....	....	....	are on this video	....
8:28:09	....	....	....	tape?	....
8:28:10	....	....	uhhhhhhhh	.... xxxx it's a research	....
	....	....	hhhhhhh	tape, ... not	....
	....	....	....	medical resarch	....
	....	....	.... sure	anthropological research	....
	....	....	sure	.... thank you	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	....	I know they asked a lot of	....
	....	....	....	people	
	....	....	....	up here, John Mxxx	....
8:28:20	....	....	....	but I want	....
	....	....	....	to make sure that nobody is	....
	....	....	....	being imposed upon	....
	....	....	no I	....	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	accommodating her	....	....
	....	....	....	....	....
	!*****!	....	right	....	....
	....	....	....	....	....
8:28:30	....	....	....	....	....
	....	....	....	....	....
	....	....	....	....	....
	....	....	because she is a doctor	....	....
	....	....	....	....	....
	....	!****!	....	....	....
	....		if it were anybody else	....	
	....	yeah	....	....	....

Appendix E

TRANSCRIPT IV
Seconds 9:18:30 to 9:19:00

Time	Wife	Husband	Anesthesiologist	Researcher
9:18:30	....	....	....	....
	....	....	....	....
	....	....	No. Don't worry its	....
	.... feel guilty?	....	not going to wear out	....
	....	....	.... over time you'll get	....
	....	....	more comfortable	....
	feel guilty?	....	.... do I feel	....
	.... yeah	....	guilty	....
	....	....	why feel guilty?	xxxxxxxxx
	xx still having pain	....	.... I think I did a good job	....
9:18:40	.... still having	....	....	....
	pain	....	....	....
	I just want to know	....	....	....
	am I supposed to feel it	....	....	....
	....	....	oh, it should it	....
	no cause in my other labors	....	should be much, it should	....
	....	....	be much better	....
	no, in my other labors	....	....	....
	....	....	....	....
	I didn't feel any pain	....	....	....
9:18:50	.... yeah	....	really?	....
	....	....	.... the	....
	....	....	one with the forceps	....
	....	....	and the	....
	....	....	in the O.R. and	....
	....	....	what was the other one?	....
	[General ******* LAUGHTER]			
		yeah	....	....
	listen you want to hear	....	....	....
	about	....	....	....
9:19:00	the C section?	....	....	....

Appendix F

TRANSCRIPT V
Seconds 9:19:30 to 9:19:59

Time	Wife	Husband	Anesthesiologist	Researcher
9:19:30	he was trying to do	....	....	....
	my sensory level	....	....	....

(*Continued on next page*)

(*Continued*)

Time	Wife	Husband	Anesthesiologist	Researcher
	.... with the	....	.... ah ah	....
	alcohol wipe	....	....	....
	....	....	oh, that's great	....
	kept saying even though I	....	....	....
	couldn't I couldn't	....	....	....
	feel the alcohol wipe ...	....	....	....
	.....	....	....	....
	kept saying I could	....	yeah, I can	....
9:19:40	.feel it	....	still feel yeah give me	....
	xxx gave me so much I'm	....	more medication	....
	telling you I was in the	....	....	....
	recovery room for five	....	....	....
	hours.....	....	....	....
	numb .... they brought me	....	....	....
	back I thought I was... like	....	....	....
	never going to ¡walk again!	....		....
	[General ******* LAUGHTER]			
	I had so much	....	she is dangerous you know	....
9:19:50	....	she is dangerous because	....	....
	... ¡*******!	she"ll keep asking for it	....	....
	....	....	....	....
	....	no, I can still feel it	....	....
	.... I had a	xxxxxxxx	....	....
	shaking reaction right after	....	....	....
	the C section when I was still	....	....	....
	in there you know everyone	....	....	....
	was 'look at this baby' and I	....	....	....
	was	....	....	....

Acknowledgements

Many colleagues and students gave us most useful comments about this work, particularly Lesley Bartlett, Charles Goodwin, Marco Jacquemet, JoAnne

Kleifgen, Ray McDermott, and Fran Vavrus. We are particularly grateful to "Lonnie", her husband, doctors and nurses for allowing us into such a significant moment in their lives.

Notes

1. We are, of course, deliberate in listing more dramatis personae than there are actors: all actors can shift which personae they are to occupy at any one time.
2. We follow a convention proposed by Varenne and McDermott (1998) and capitalize scenes, settings, procedures, and institutions that are heavily controlled by major social and processed processes when we wish to index politically salient properties that can be used, often outside the local setting, to constitute the setting as a particular kind of setting.
3. This paper is an aspect of the larger agenda that Varenne has developed with other colleagues, mostly in the arena of schooling and education (Varenne, 1984a; Varenne and McDermott, 1998; Mullooly and Varenne, 2006; Varenne et al. n.p.)
4. This analysis is based on extensive work done on this labor and delivery by Mary Cotter (1996). Cotter's study focuses on the interactional production of contractions as a particularly telling instance of collectivity during what is, ostensibly, an intensely intrapersonal event. What appears, common sensically, as something that happens deep within the body of the laboring woman can be shown to involve all participants; together with the woman we call "Lonnie," they account for the strength of the contraction, and deliberate about the amount of pain she is "really" feeling. This is brought into sharp focus after the administration of epidural anesthesia, when the output of the fetal monitor becomes key in the interactive construction of how well the labor is progressing. Cotter discusses in detail the many kinds of talk performed during the labor and their participatory structures.
5. Cotter followed Lonnie throughout her pregnancy, attending and videotaping all prenatal visits to the obstetrician, as well as the entire labor and delivery, the last two hours of which are the focus of the present article. Cotter gained access to this setting through her acquaintance with Lonnie in another context. Permissions to videotape physicians and hospital personnel were sought, and granted, at every phase of the research. Cotter's sister, a nursing professor known to some of the hospital staff, facilitated contact with the nursing department for permissions to videotape the nursing staff.
6. This, obviously, is a pseudonym. Our justification for using a first name lies in the fact that this is the way the woman/wife/mother is addressed and referred to by all participants. The anesthesiologist, once at least, does start a greeting sequence with a "Mr. and Mrs. McDowell." We must note, in the spirit of Clifford Geertz's famous essay on naming in Bali (1966/1973), that by not referring to woman/wife/mother as Mrs. McDowell, we directly participate in the erasure of one of her main statuses (that she is married and that part of her total social self is constructed by her association with Mr. McDowell). By not naming him (following the lead of the participants again, who rarely if ever directly address or refer to him by his name) we perform the same kind of erasure. His professional status, for example, is never marked.
7. Details about transcription conventions can be found in Appendix A.
8. This is an extension of recent work on "text" and "context" (Duranti and Goodwin, 1992).
9. In the few cases when both obstetrician and anesthesiologist are together in the room, one can observe an intricate dance as each doctor yields to the other for specific tasks. As one doctor moves away, he shifts into the position of the other un-authoritative participants as they chitchat for the duration of the examination.

10. During all showings so far, if any in the audience picked up on the special status of the laboring woman, they never spoke up to argue with the identifications made by others in the audience.
11. This is another application of an idea originally developed by Lee Drummond in his writing on motherhood (1978).
12. Here again, while the smoothness of the process suggests much shared knowledge, the evidence for any statement about the extent of this knowledge would have to consist in the absence of redirection by anyone toward anyone else. However, there is no way to sort out whether knowledge is shared or whether any participant is just "passing," paying close attention to smaller cues and thus fitting with the scene *as if* he or she knew.
13. We have chosen the word "examination" in deference to Michel Foucault's early attempts at understanding medical procedures as historical, cultural, and externally factual, processes (1963/1973, 1975/1978). The general features of the examination emerging in this case study are the same as those described in all such research out of discourse analysis and other interactionist studies (Heath, 1986). They are also structurally similar to those first analyzed in Jordan's work (1978/1993). Structural similarity is not be taken to mean that all details of this labor were the same as the published details from earlier work. The authoritative doctors, in our case, spent much more time on "chitchat" than the doctors in other published research.
14. The easiest definition of "canonical" here is "according to an observationally derived ethnomethodological rule." As Bourdieu emphasized repeatedly, there is something dangerous about the word "rule," particularly if it is taken to imply a property of agents following a prescription that they have internalized. Methodologically, we intend here to sketch "what might happen if nothing else happened." The canonical form is derived from observing what participants notice. In the ethnomethodological shorthand, the canonical form summarizes, for analytic purposes, "what the participants take into account." It does not "exist" as such. In practice, we see participants index "something" that is often not named or described as such, though analysts, for their own practical purposes, may find it useful to write an account of "that which is indexed." Such accounts can take a life of their own in the research and political literatures. There is a danger here that we are trying to escape. The "canonical form" is closely related to the concept of "positioning" in the work of Scheflen (1973) and McDermott (1978). This is less obviously related to what Lévi-Strauss talked about as "structural models" (1952/1963: 279–280). A canonical form is an attempt by the analyst to account for a property of that which the participants, together, have "facted" (constructed, constituted) for each other, their consociates, and descendants.
15. It is of course not the case that this form is never available for negotiation or stage direction. Hospital administrators, medical researchers, architects, bed designers, etc., all, at various times and places, do discuss the overall frame for labor. They just did not do it during this labor nor in any of the labors described in the literature, nor, we suspect, during any particular labor (unless perhaps for researchers, from within or without medicine).
16. Jordan has written extensively about this (1989, 1992, 1978/1993). This is in fact a general point as demonstrated in a recent paper by Alison Pilnick and Jon Hindmarsh on the work of anesthesiologists before surgical procedures (1999). They show the actual interactional work doctors must perform as they balance technical requirements and the patient's own work in response to theirs.
17. Varenne has explored how this works within routine family interaction (1992).
18. While the event as a whole may demonstrate the power of this status (though we would prefer to see in the overall tone of the event a matter of class), it required much less local work than the research. Lonnie's choices place her more in the category of "Lay Middle-Class Woman" rather than "Health Professional" in the terms of Ellen Lazarus's work (1997).

Lazarus documents other cases where the professional status of women doctors was not consequential for their treatment in hospitals where they were known as doctors.

19. Footnote 4 gives details about the process of getting permission to conduct the research. This is only intended to suggest how "giving permission" may be transformed into an interactional sequence within the larger sequences about which permission to observe becomes, in this culture, a possible, allowable, and even necessary, sub-sequence.
20. Harvey Sacks has shown how complex is the interactional determination that a statement is indeed a lie for local purposes, including what kind of lie it might be taken to be (1975). Exploring these possibilities would take us too far.
21. The issue for us is not so much that "the imposition of meaning on life is the major end and primary condition of human existence" (1972/1973: 434) but that the participants must, at such times, fully face the consequences of their cultural condition. We are pushing another of Geertz's sentences in this famous passage: "Having come together in search of pleasure [the participants] have entered into a relationship which will bring the participants, considered collectively, net pain rather than net pleasures." "Considered collectively" is the key term. Recently, Sherry Ortner (1999) has begun investigating similar matters in what she calls the "serious games" Sherpas and those whom they guide engage in as they risk their lives climbing the Himalayas.
22. Grey Gundaker has recently reminded us of the dangerous work conducted by recent arrivals from Africa in the United States under condition of slavery as they discovered the importance of literacy and taught themselves to read in spite of the direst of consequences should they be discovered knowing how to read (1998).

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