

## Medication and morality

### Analysis of medical visits to address chronic pain

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#### Introduction

Research about language and health in the context of chronic pain is international in scope (Alamo et al. 2002 (Spain); Bieber et al. 2006 (Germany); Haugli et al. 2004; Laerum et al. 2006; Eggly and Tzelpis 2001 (USA); Werner and Malterud 2004 (Norway); Kenny 2004 (Australia)), but surprisingly sparse. Considering that pain-related complaints are among the top 20 reasons for visits to the doctor (similar in frequency to well baby exams, complaints of fever, and skin rash (NAMCS 2008)) and that the medical use of opioids has increased by a factor of 10 since 1990 (Okie 2010), there is clearly a need for analysis of the language practices that constitute medical visits where pain and pain medications are discussed. Research has addressed how patients describe their pain (see Salovey et al. 1992 for a review), but the interactional dynamics of primary care encounters for pain management are as yet underspecified. In this chapter we address this gap in knowledge by focusing on the moral dimension of these visits, specifically examining stances regarding pain medication as embodied in patients' and physicians' language practices.

But why focus on the moral dimension of these interactions? We introduce here, and explain further below, two key reasons: (1) morality inheres at all levels of interaction and is therefore foundational to the study of any language event (Bergmann 1998; Linell and Rommetveit 1998), and (2) until we take seriously the study of the moral landscape in health care, as produced in participants' interactions, we will not be able to fully grasp how best to devise interventions and training for improving health communication (Maynard 2003; Churchill 1997).

To date, the focus of the research on chronic pain in medical encounters has examined decision-making styles as they relate to both patient satisfaction and health outcomes (Alamo et al. 2002; Bieber et al. 2006; Laerum et al. 2006). Using message-coding methods (Eggly and Tzelpis 2001), focus groups (Haugli et al. 2004), and interviews (Werner and Malterud 2004; Kenny 2004), this international effort has been concerned primarily with understanding the therapeutic relationship in the pain management

context. However, what is left unexamined is the normative and evaluative work within these healthcare visits. Understanding this interactional work, using actual medical encounters as the empirical basis for knowledge building, is where language scholars can contribute to the development of communication strategies appropriate for pain patients. Potentially, there is room to develop more sensitive and holistic practices for assessing pain and for discussing pain management.<sup>1</sup>

This study, which draws on audiotaped interactions between primary care physicians and persons with chronic pain, will focus on the issue of medication use and addiction. This choice is made because of the tendency to perceive those complaining of chronic pain as potentially merely drug seeking (Elder et al. 2006) or as having underlying psychological rather than biological conditions (Chibnall et al. 1995; Holloway et al. 2007). As this analysis demonstrates, patients orient to these concerns by deflecting the 'addict' characterization, by cooperatively constructing and therefore displaying an understanding of addiction, and by representing themselves as responsible users of medication.

### Morality in discourse

Two kinds of morality must first be distinguished before embarking on the current analysis. As identified by Bergmann (1998) and Linell and Rommetveit (1998), there is a 'proto' or 'elemental' morality which is present in *any* dialogic activity; it is the reciprocal ascription of responsibility for behavior in a world held in common (Bergmann 1998: 284). This proto-morality or 'discourse internal ethics' transcends cultural and historical contexts; Maynard (2003) refers to this as the *morality of discourse*.

Built upon this fundamental moral structure is the more commonly understood, second-order morality which refers to topics 'as they are coped with' in interaction and to which evaluative or normative attitudes are explicitly or implicitly addressed (Linell and Rommetveit 1998: 466). This second form, *morality in discourse* (Maynard 2003), tends to be culturally and historically specific and is the form of morality explored in this chapter. It is also the form scholars refer to when calling for better mapping of the moral landscape in medicine (Churchill 1997). However, because medical interactions are primarily service encounters (Jefferson and Lee 1981), moral issues are generally subordinate to the practical exigencies of providing healthcare services (Heritage and Lindstrom 1998). Thus, while patients may display an orientation to health behaviors such as smoking, drinking, or weight loss as morally laden (as good or bad), (Halkowski 2012; Webb 2009) medical professionals tend to treat these behaviors in a more neutral or bureaucratic manner (Linell and Rommetveit 1998: 470); for example, by refraining from commenting on patients' self-assessments (Webb 2009). Some medical domains, such as psychiatric intake interviews (Bergmann 1992) and midwifery (Linell and Bredmar 1996) are treated by both provider and patient as morally sensitive, but morality is not a topic of conversation. Thus, to get a glimpse of the moral landscape in medical interaction we attend to what is enacted through language and embodied action, through implicit or explicit claims, judgments, ascription of obligations, and so on. Attention to this more subtle interactional work can help reveal the normative and evaluative contours of the pain context.

### Materials and methods

The materials for this analysis are based on close transcription and analysis of 21 audio recorded clinic visits in which chronic pain was the patient's chief concern. The visits were

in the same primary care clinic and were collected over approximately four months in 2004 and 2005 (Kramer 2008). The 12 physicians included in the study were family practice specialists.

The analytic framework and technical toolkit for the analysis are grounded in conversation analysis which privileges co-participants' displayed orientations to producing and making sense of social actions through their vocal and embodied practices (Sacks et al. 1974; see also Heritage 1984; Pomerantz and Fehr 1997). This chapter presents three exemplars to support the theoretical proposition concerning the interconnectedness of language practices and moral order. The goal is not to generalize to the population of chronic pain sufferers, but to open the door to consideration of the features of the pain context that are constituted through talk-in-interaction.

### Analysis

Of the 21 visits recorded, 12 involve a routine return visit of chronic pain patients. We take three of those cases to serve as exemplars of patients' orientation to medication use and addiction as moral issues. In the first case a patient works to retrospectively account for her non-prescription ibuprofen use as responsible, not addictive. In the second, a patient and physician co-construct the dangers of dependence on opiate medication. Finally, having established patients' overt orientation to the moral dimension of medication use, we turn to an extended analysis of a patient's request for the refill of opiate medications, unpacking the more subtle interactional work that constructs such a request as morally laden.

#### *Explicit orientation to medication use as a moral issue*

Two cases are presented in this section to exemplify patients' explicit orientation to the moral dimensions of medication use, even the use of non-opiates, and the ostensibly related issue of addiction.

Patient A is a 40-year-old woman who has experienced chronic back pain for 12 years. The current visit is a routine follow-up to review her pain status and medications, but she also raises a new concern: recurrent, severe headaches over the past two weeks. As part of a series of questions to diagnose possible causes of the headaches, the doctor asks the patient what alleviates the pain. The patient reports taking 'Advil' which is one of many brand names for non-prescription ibuprofen, a non-steroidal anti-inflammatory. Although the amount of ibuprofen the patient reports taking is not unusual (600 mg) she engages, nonetheless, in extended interactional work to back off of the self-disclosure as though it were an indicator of improper use. The larger than recommended dosage can indicate that she is experiencing severe pain and therefore pushing the limits of proper use, but she moves to construct a portrait of herself as someone who would not knowingly go over such a limit. The moral implication is that she is favoring rational action over pain relief, thus embodying a cultural or moral value of self-restraint.

*Excerpt 1: I read the labels (Patient A; 20:00)*

- 1 DR: What makes it better.
- 2 PT: Laying down. Taking, taking three- ya know I take- almost six hundred
- 3 milligrams of ibuprofen.
- 4 (0.2)
- 5 PT: An I mean I'm not takin it till where I'm ya know addicted to it

- 6 DR: [mm  
 7 PT: [I'm spɑ:cing it out.  
 8 DR: mhm,  
 9 PT: Ya know cuz I know:: I read the labels °and everything° so I'm not  
 10 taking it one right after the other.=  
 11 DR: =Sure.  
 12 PT: Ya know an ɔvərdosing on the advil.=  
 13 DR: =Right.  
 14 PT: Cuz I'm just not that way.  
 15 DR: mhm.

In line 2, the patient first reports 'laying down' and then taking ibuprofen, initiating a self-repair on the dosage information. She moves from the presumably less medically precise number of pills ('three') to a more technically accurate, though not entirely clear-cut measure of 'almost six hundred milligrams' (lines 2–3). Although over-the-counter ibuprofen is generally dosed in 200 mg pills, there can be some variation by brand, thus the repair on the metric (from pills to milligrams) indexes a move toward both precision and self-awareness of consumption. In contrast to research on patient alcohol reports, which finds that patients have a tendency to use 'nonstandard metrics' to resist physicians' efforts to generate specific alcohol usage rates (Halkowski 2012), this patient offers a nearly precise, and technically relevant, measure of ibuprofen usage. Since the recommended over-the-counter dosage for adults is 200–400 mg, the hedge 'almost' (line 2) on the 600 mg indicates that she is approaching a threshold of 'too much' (i.e., indexing serious pain) but, as yet, not quite over an acceptable limit.

From a structural and pragmatic standpoint, the sequence initiated by the physician's question could now accountably be complete. The information provided by the patient addresses the conditional relevance (Schegloff 1968) set up by the initial question; she has reported both laying down and taking medication to address her pain. However, exploiting the brief gap at line 4, the patient self-selects, adding additional, unsolicited information about *how* she takes the ibuprofen, treating her prior report as requiring something further.

Indeed, the ensuing talk (lines 5–7) deflects any implication about addiction or irresponsible behavior. At line 5, the 'An I mean' preface, indicates a correction on her prior talk, recasting the description ('six hundred milligrams') as in need of clarification. This seems an implicit recognition that 600 mg could be misunderstood as indicating a larger than recommended single dosage, something possibly indicative of irresponsible behavior. The utterance develops into a claim that she is not 'taking it till where [she's] addicted' (line 5), thus explicitly invoking a morally laden term and simultaneously deflecting it.

The patient's use (at line 5) of 'till where' (similar to 'almost' at line 2) implies someone on the verge of, or at the boundary of, some acceptable line between responsible and irresponsible behavior. The physician doesn't assess any of the talk so far; although there is an opportunity at the transition relevance place at the end of line 7, where the utterance is grammatically and prosodically complete (Sacks et al. 1974; Ford and Thompson 1996). Rather, at line 8, the physician passes the floor back to the patient who, perhaps in pursuit of some recognition of the appropriateness of her behavior, produces a characterization of herself as someone who regularly reads and follows label instructions (note the present tense and plural noun 'labels' at line 9).

The physician acknowledges the report with a confirming 'sure' (line 11) which could be the end of this now expanded sequence (i.e., expanded beyond the initial response to 'what

makes it better'). However, at line 12, the patient moves to further deflect any implication she is improperly using 'advil' or, by extension, any other medication (line 14). In line 12, she deploys the term 'overdose' which is both technical and moral; overdosing can indicate anything from accidental to irresponsible to willfully negligent use of medication. While it can project all of those meanings, here the patient is confronting a meaning of negligence or moral weakness: she builds her utterance at line 12 as a continuation, linked through its parallel grammatical structure (present progressive) to the prior negation 'so I'm not taking it one right after the other ... and overdosing on the advil' (lines 9–12), causally connecting (with turn-initial 'cuz') that claim with the further self-characterization that she is 'just not that way'.

In sum, by invoking then deflecting any implication of addiction, the patient displays an overt orientation to use of this relatively benign, over-the-counter medication as a moral issue; moral in the sense that evaluative/normative attitudes are explicitly or implicitly addressed (Linell and Rommetveit 1998). While the doctor displays uptake of the patient's talk (lines 6, 8, 11, 13, 15), she never assesses or pursues it either positively or negatively; the interactional space is simply left open. It may well be that the physician's neutral stance is actually contributing to what we might gloss here as the patient's defensive posture. Possibly in pursuit of an assessment or some form of reassurance from the physician, the patient extends her initial report to account for her ibuprofen use as responsible.

In the next example (Excerpt 2, below) it is the physician who introduces the topic of medication ('the problem with narcotics'). He treats it in a technical manner, while the patient displays an arguably moral stance.

Patient B is a 33-year-old male who has been experiencing ongoing pain from screws in his knee which were placed there during surgery following an accident. This is a routine follow-up visit in which he reports increasing sleeplessness. The physician implicitly suggests it may be connected to increased pain, given an apparent effort to reduce the patient's opiate medication. The talk then turns to 'the problem with narcotics.'

*Excerpt 2: Weaning down (Patient B; 1:55)*

- 1 PT: It's jus gettin to the point where I hh I'm not sleepin at night, uh::m  
 2 (0.6) .tch (0.2) jus gettin, (0.6) it's gettin, it's gettin ba::d.  
 3 (2.0)  
 4 DR: .hh An (0.2) we've been tryin ta wea::n down the  
 5 narcotic[s]  
 6 PT: [yea::[h  
 7 DR: [Are you noticing a difference:?  
 8 PT: Yeah. Pain [wise, ]  
 9 DR: [Pain is] worse?  
 10 PT: Up.  
 11 DR: The problem ya know with narcotics are that  
 12 PT: They're- you can get uh:m  
 13 DR: You get tolerant.  
 14 PT: Tolerant and uhm (.) possibly addictive.  
 15 DR: Yeah. There's w- there's a wert- your body can become dependent on it,  
 16 PT: mm=  
 17 DR: =you can become addicted, and your body can become tolerant.  
 18 PT: uh huh.  
 19 DR: What happens with the tolerance is that your- you end with more

- 20 [receptors,  
 21 PT: [you need more. Need more [and more ]  
 22 DR: [so you need] more and more narcotic ta  
 23 PT: keep goin.  
 24 DR: right.

In lines 1–2, the patient reports ongoing, worsening pain. The general framing is similar to Patient A, above, in that he also describes a situation that is approaching some invisible line of reasonable acceptance ('it's jus gettin to the point' at line 1). The deployment of the present progressive along with the physical difficulty he has in producing the utterance formulate both immediacy and discomfort.

The physician responds to this description by offering a reminder about a prior decision to 'wean down the narcotics' (lines 4–5), lexically linking back, with the conjunction 'An' (line 4), the launch of his own utterance to the patient's report of things 'getting bad'. To gloss this, the physician artfully connects the patient's discomfort with the change in opiate medication, introducing 'the problem with narcotics' (line 11) as a general informing. At line 12, the patient attempts to complete the physician's utterance, displaying an understanding of where the informing may be going.

Their collaborative interactional work embodies a shared perspective and, for the moment, the 'puzzle' introduced by the doctor (about the problem with narcotics) is effectively resolved at line 13 where the physician produces the relevant technical term ('tolerant'). However, the patient does not treat the term as sufficient. He repeats it, but extends the utterance to include 'possibly addictive' (line 14) displaying recognition that the problem can be larger than mere tolerance. It is thus the patient, as in Excerpt 1, who introduces the more socially charged term, pre-emptively addressing himself to addiction as the essential 'problem' potentially indicated initially by the physician.

Although the patient has opened the door to a discussion of addiction in the context of his particular circumstances, the physician first introduces the generalized term 'dependence' and then acknowledges the pathway through to addiction and drug tolerance (lines 15–20). The second person possessive ('your body can become dependent') is an ambiguous formulation, allowing that the patient may be included in those who are dependent/addicted, but it is the more socially neutral term 'tolerance' that is topicalized (line 19).

In overlap (line 21), the patient again moves to collaboratively contribute, not in the direction of 'more receptors' which would constitute a physiological explanation of tolerance, but in the direction of an understanding that the person who is tolerant would 'need more and more' [medication] to address his/her pain. The patient's formulation is thus focused on human behavior, and moves the conversation toward human action and away from biology. Through repetition of the patient's words, extension of the utterance to include the term 'narcotic' (line 22) and a token of receipt (line 24), the physician confirms the patient's generic characterization of patients' (not yet this particular patient's) ever increasing need for medication just to 'keep going'.

In this oblique discussion of the patient's use of opiates, we catch a glimpse of the differing stances of the participants as they construct this stretch of talk. The physician's essentially technical stance embodies an institutional responsibility to help the patient understand what might be causing his increasing discomfort, but in a non-judgmental (non-moralistic) manner. This is evidenced by his focus on 'tolerance' and the biological explanation related to receptors. The patient's stance, in contrast, tends toward the evaluative and the behavioral: first, he introduces the term 'addictive' characterizing 'the problem with narcotics' as

uncontrolled or unlimited need for medication ('more and more') and concomitant dependence just to maintain life ('[to] keep goin'). These are potentially socially and culturally deviant activities that therefore pose not just a physical but also a moral challenge.

### *Implicit orientation to medication as moral issue*

The previous examples demonstrated how patients display an explicit orientation to medication use and related addiction risks as culturally/morally suspect, presenting themselves as both responsible and aware. The final example presents a case where the interactional work is perhaps more subtle, but the moral work is similar. In this case, the patient is framing, through a series of neutral reports about his remaining medication, an implicit request for an opiate prescription refill. The physician resists the implied request, putting the patient in the position of moving toward an ever explicit formulation. The patient does so, but in a manner that simultaneously suggests the extent of his pain and his reasonable approach to the medication.

Patient C is a 40-year-old male who was surgically treated for back pain and who found out, on the same day as the visit transcribed here, he will need another surgical procedure. Just prior to the excerpt transcribed below (Excerpt 3), the patient had asked if he could get the required pre-surgery physical during the current visit, but the doctor responds she is too busy that day. Line 1 of Excerpt 3 thus refers to scheduling that pre-surgery visit. Once that business has been attended to, the main reason for the visit is raised by the patient: refilling his prescriptions for Oxycontin (the brand name for generic oxycodone, a federally controlled opiate analgesic) and Endocet (a combination of the opiate oxycodone and acetaminophen, a nonsteroidal anti-inflammatory). The patient refers to these medicines as 'oxycotten' and 'ambiset' and they are transcribed as such, below. The patient also refers to 'breakthrough pain' which is the medical term for pain that occurs between scheduled administrations of analgesics and which is handled by other medications, in this case with Endocet.

#### *Excerpt 3: Request for oxycontin & endocet refills (Patient C; 1:25)*

- 1 PT: So you'll just hafta: schedule me,  
 2 DR: Okay.  
 3 PT: For that=But<sup>b</sup> [basically I'm I'm- (0.6) I'm outta  
 4 DR: [(wha-)  
 5 PT: the oxycottens that ya gave me,  
 6 DR: Okay.  
 7 PT: But I still have like thirjy of the ambiset?  
 8 (0.6)  
 9 DR: [°mmm° ]  
 10 PT: [And uh-] the surgery's gonna be au:gust fifth,  
 11 DR: [mkay.  
 12 PT: [So what is it uh :: (.) so: actually the thirty day period (.) I won't  
 13 see ya next month. Because #I'll be havin surgery I'll be in the  
 14 hospital.#  
 15 DR: You mean you're not gonna: s[neak \$aw]ay and come see me? \$  
 16 PT: [°°hh°° ]  
 17 PT: heh heh.=  
 18 DR: = \$Just kidding.\$=

- 19 PT: =Yeah maybe in a wheelchair. [Ha ha ha ha ha .hh]  
 20 DR: [Okay. (0.2) Alright.]  
 21 PT: .hh Uhm ((clears throat)) So I guess I just (1.0) you know basically  
 22 need (.) some more oxycotten, and maybe[thirty]  
 23 DR: [m h m ]  
 24 PT: ambiset because I [probably] got (0.4) fifteen to twenty of the  
 25 DR: [mhm:: ]  
 26 PT: ambisets left out of the sixty you gave me.  
 27 DR: Mhm.  
 28 PT: .hh And I been (0.2) pretty much eatin a lotta them for breakthrough  
 29 pain. ya know.  
 30 DR: [Hm  
 31 PT: [Stickin to the (.) ya know stickin to the thirty, (1.0) uh milligrams  
 32 a oxycotten?  
 33 DR: [Mhm.  
 34 PT: [Ya know up in the mornin and at night. But eatin a lotta the ambiset  
 35 for breakthrough pain.  
 36 DR: Mh[m  
 37 PT: [ya know. So.  
 38 DR: Okay. How's is your p[ain?  
 39 PT: [And ahhhh Bad. hhhh  
 40 DR: How is it compared to last time I saw you?  
 41 PT: Ehh bout the same.= I'm (.) bout a nine.

In lines 3–5, the patient completes his utterance about scheduling the physical and then rushes through the transition space (Schegloff 1987) to produce a report that he is out of oxycotin. At this point in the sequence, the launch of the utterance with the contrastive conjunction 'but' is hearable as transitional to a now official 'first topic' of this service encounter (Robinson 2006; Schegloff and Sacks 1973; Zimmerman 1992). Note, however, that the utterance is simply a report, not a grammatically formulated request for a medication refill. In everyday settings the report/description format serves (at least) two functions simultaneously: (1) as a vehicle for an implicit request (Drew 1984; Schegloff 1988, 1995), and (2) as a means to avoid an official stance on some matter at hand (e.g., see Drew 1984 on the use of reports for rejecting invitations). This same potentiality provides a resource in medical settings for patients to make requests without actually asking (Gill et al. 2001; Robinson 2001). In the current instance, however, the physician never engages with the patient's report as a request; she co-constructs this as the patient's multi-unit turn in progress, providing tokens of uptake or continuers (lines 6, 9, 11), but never actually addressing the implicit request.

The moral work getting done to this point can be analyzed from several vantage points. Through this series of reports, the patient avoids 'intruding on the doctor's medical judgment' (Robinson 2001: 33), simultaneously indexing the delicacy of the implicit request for opiates and the delicacy of making a request of one's physician. Further, by not setting up conditional relevance of a response (i.e., a request has not actually been articulated) the patient leaves open the possibility of refusal. Thus, in terms of rights, responsibilities, normative and evaluative attitudes (i.e., *morality in discourse*), the talk so far embodies the patient's orientation to the issue of the medication refill as (a) potentially problematic, (b) potentially indelicate, and, therefore, (c) potentially refusible.

For her part, the physician is not making it obvious that she is sympathetic to the implication of the patient's reports. While his description of using up the medication might be an indication of the patient's pain level, the physician does not assess or seek clarification in that direction (see Robinson 2001 for a contrasting case). Indeed, her resistance to the patient's request becomes more salient as the interaction continues. The patient offers new information: because of the surgery date, he will miss his next opportunity to get his prescription refilled ('won't see ya next month' lines 12–14). Here the physician accountably avoids the implication by simply fitting her response to the surface content of the utterance: she makes light of it through a non-serious, arguably ironic or even flirtatious question (line 15, 'You mean you're not gonna sneak away and come see me?'). The patient laughs briefly (line 17), but the apparent failure of the doctor's joke (as evidenced by the physician's recourse to the explanation 'just kidding' at line 18) is underscored by the patient's troubles-resistant laughter (Jefferson 1985; Glenn 2003) at line 19.

Exiting this joking episode in a distinctly non-jocular tone, the patient now expresses an explicit and specific 'need' for more medication (lines 21–26), which he accounts for by his (revised) estimate of the number of Endocet he has remaining. Interestingly, the number of pills he now claims to have (15 to 20) is actually far less than the 30 he originally mentioned (line 7). If the physician is listening carefully, this could cast aspersions on the patient's reliability; however, the fact that he describes himself as 'eatin a lotta them' (line 28) for breakthrough pain could also account for any impression of imprecision: the formulation indexes breakthrough pain that is frequent and serious enough that he may not actually have a concrete idea of how many pills remain. Whether the patient knows or not, whether the physician is listening carefully or not, neither of these questions can be answered here. What is clear, however, is that the smaller amount of remaining medication can work to upgrade the urgency of the need for the refill.

Paradoxically, such unobserved and possibly uncontrolled use could be construed as irresponsible; however, to briefly characterize what ensues, the patient then presents a more clinical description of the oxycodone use: taking them twice a day as directed at the dosage directed (lines 31–34). Thus, the patient's re-mention of 'eatin a lotta the ambiset' (line 34) is now in a context of responsible (i.e., prescribed) oxycodone use. The implication to be drawn is that the underlying pain is severe enough for him that the oxycodone is not sufficiently handling it, since he often resorts to breakthrough medications.

The moral landscape is thus similar to the previous cases: patients are managing responsibly in the face of pain, but they present themselves as being at the brink. The fact that they are at the doctor's office is evidence of rationality in that they are 'appropriately' (morally, correctly) seeking medical intervention (see Halkowski 2006 on 'the patient's problem'), but the interventions they seek are potentially suspect. Thus, these patients embody, through talk-in-interaction, an awareness of the social and cultural values that inhere in the practice of using pain medications, even when those substances are medically indicated.

### Future directions

Understanding the moral dimension of medical encounters in the chronic pain context provides a basis for connecting micro-linguistic practices with public health issues. This study is among projects aiming toward such trans-disciplinary knowledge, as described in Kreps and Maibach (2008), and effectively realized in applied conversation analytic research (e.g., Heritage et al. 2010; Mangione-Smith et al. 2006; Stivers 2007). Studying the language practices that lead to prescription of pain medication is admittedly only one piece of a highly

complex public health puzzle concerning over-prescription and diversion of opiates (Okie 2010), but since there is so little empirical research based on actual interactions in the pain context, the field is wide open for investigation, innovation, and theorizing. Indeed, pain education is generally lacking in medical curricula (Lippe et al. 2010); for example, only five of the 133 medical schools in the United States require courses on pain (Committee on Advancing Pain Research 2011: 366). The time is ripe, therefore, for studies of the pain context which take into account participant orientations as expressed through language and embodied action. This kind of research will afford scholars foundational material for developing empirically grounded and interactionally relevant training and education programs.

Three observations made in this chapter could be pursued. First, there may be a contrast in orientation toward pain medication use and alcohol consumption, and specifically how we talk about those substances with physicians. It seems that precision about medication use is favored, in contrast to patients' resistance to precision in the alcohol reporting context (Halkowski 2012). A second and related observation is the possibility of a preference by patients to display stoicism by reporting attempts to manage pain with physical interventions before reporting use of medication (e.g., Patient A). And third, that pain patients present themselves as managing in the face of their difficulties, but just barely. These last two observations point to tensions in the health context that could be further examined in light of Halkowski (2006) and the concept of 'the patient's problem' or the fine line between involvement and detachment. Importantly, researchers might explore patient-physician communication in the realm of cancer pain, where patients clearly have etiology, yet may still struggle with receiving sufficient pain medication (NIH 1997), even within the hospice setting (Kimberlin et al. 2004). Likewise, it would be enlightening to explore the context of complementary/alternative medicine, as there is currently no research that examines interactions between chronic pain patients and their complementary or alternative care providers.<sup>2</sup>

### Summary

This chapter started with the premise that morality inheres at all levels of discourse and is therefore a relevant target for linguistic analysis. In the health context, only a few studies have developed this approach; thus, the current analysis attempted to fill that gap by sketching how patients treat the issue of addiction and their own medication use as morally laden. We found that they did this by explicitly raising and deflecting these related concerns or by collaboratively constructing, and thereby displaying, their understanding of the issues. The work patients do through language reveals they are alert to the moral implications of medicine as palliative: all three patients project restraint, awareness, and responsibility, indicating they view these moral qualities as relevant dimensions to be addressed. In other words, patients reveal through the content of what they say, when and how they say it, and by the collaborative interactional activities they engage in with physicians that moral character is at stake and must be defended.

We have also seen that, in line with prior research, physicians tend to take a bureaucratic or neutral stance within these pain-related interactions, treating these encounters as having no particular moral content. Interestingly, it is the patients themselves that display sensitivity, through their own language behavior, to the issue of addiction. Although the physician in Excerpt 3 does take a more resistant stance to the patient's implicit request, potentially treating it as inapposite, that implication recedes under cover of favoring scientific (chart-

relevant) measures of the pain experience. Admittedly, these initial findings require further elaboration, confirmation, and refutation as we continue to refine our understanding of this important domain in personal and public health.

### Related topics

Pain medication; morality in discourse; addiction; physician-patient interaction; prescribing.

### Notes

- 1 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires its accredited organizations to include pain as a vital sign to be collected from all patients on initial intake (Rosenfeld 2003). However, there is no systematic means to assess pain (Lippe et al. 2010); many organizations, including the US Veterans Affairs, simply use a 0 to 10 scale for patient pain severity self-report (Mularski et al. 2006).
- 2 However, one study comparing physicians and chiropractors generally found that patients suffering from low back pain who saw chiropractors were more 'satisfied' than those who saw physicians (Hertzman-Miller et al. 2002). The higher satisfaction ratings were based on communication factors such as information giving and advice.

### Further reading

- Drew, P. and Wootton, T. (eds) 1988, *Erving Goffman: Exploring the Interaction Order*, Cambridge: Polity Press. (A collection of essays that contemplate and critique Goffman's concept of the interaction order, examining morality among other key constructs.)
- Hilbert, R.A. (1984) 'The acultural dimensions of chronic pain: flawed reality construction and the problem of meaning', *Social Problems*, 31(4): 365-378. (This is foundational for understanding how language and culture prohibit pain sufferers from relating their subjective experience.)
- Shorter, E. (1997) 'Somatization and chronic pain in historic perspective', *Clinical Orthopaedics and Related Research*, 336: 52-60. (This is a comprehensive overview by a prominent historian of medicine about the emergence of chronic pain as a cultural phenomenon.)

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