VERBAL PLAY AND MULTIPLE GOALS IN THE GYNAECOLOGICAL EXAM INTERACTION[1]

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Abstract This report investigates audio-taped gynaecological exam interactions that took place between one nurse practitioner and 41 female patients. Twelve instances of verbal play were transcribed from these exam conversations and analysed in order to demonstrate ways in which play sequences display participants' orientation to non-medical goals of the exam. Such goals include recognising the practitioner and patient as persons rather than as technician and technical object and reducing the face-threat of the exam. It is suggested that the analysis of naturally occurring conversation permits access to the conversational practices used by interactants both to generate and to achieve multiple goals.

Extract (1)

1 **LNP:** um we're now doin' a chlamydia test on the girls have you read
2 anything about chlamydia?
[ ]
3 **P:** uh uh
4 **LNP:** okay chlamydia's a sexually transmitted disease
(1.5)
5 **P:** Something new ha ha ha ha
[ ]
6 **LNP:** heh heh heh um hm something new to pick
7 up=
8 **P:** =ha ha=
9 **LNP:** =and they're finding that uh girls usually don't have any
10 symptoms of it but if it goes untreated it could cause scarring
11 of the fallopian tubes

While laughter may indeed be the best medicine, the gynaecological exam is not a context in which we would expect it to surface, except, perhaps, for the occasional nervous twitters that accompany uncomfortable events. In the above con-

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versational fragment, a female nurse practitioner informs the patient in line 1 that the exam procedure now includes a chlamydia test; when the patient denies having read anything about chlamydia in line 3, the nurse explains that it's a sexually transmitted disease. After a brief pause in the interaction, the patient jokes 'something new', following this assessment with laughter. Describing a venereal disease as 'something new' gets interpreted as playful by the nurse, not only because of the patient's laughter that follows it, but also because of the incongruity of the use of the word 'new', which in our culture commonly means 'new and improved'. The nurse validates the laughability of the phrase through immediate shared laughter in line 6 and a repetition and extension of the patient's humour — 'something new to pick up'.

In the midst of preparations for the pelvic exam, the nurse and patient have collaborated to produce a sequence of play which may be extraneous to the medical procedure of the exam but which, through its reliance on tacit knowledge, helps link nurse and patient as people cooperatively engaged in a task, rather than as mere technician and technical object. This report will analyse similar instances of verbal play as they appear in naturally occurring discourse between a licensed nurse practitioner and her female patients; its aim will be to demonstrate the ways in which play sequences display participants' orientation to non-medical goals of the exam.

Multiple Goals in the Gynaecological Exam

Whereas multiple task and face goals likely operate in all interpersonal interactions (Craig, Tracy, & Spisak, 1986; O'Keefe & McCormack, 1987; O'Keefe & Shepherd, 1987; Tracy, 1984; Tracy & Moran, 1983), the unique medical context of the gynaecological exam suggests that multiple goals are both inherent and, potentially, in conflict; achieving the medical goal of the exam intrinsically threatens the face needs of both participants. The medical goal of the exam is explicit and unequivocal: the gynaecological exam is performed in order to diagnose and to treat disorders of the female reproductive system. Since the development of the Pap test, which is used to detect the early presence of cervical cancer, the exam has become a particularly critical intervention in the early diagnosis and treatment of women's reproductive cancers. This medical goal is paramount to both patient and health care practitioner in the exam procedure; thus the joint goal of cooperation is necessary to ensure that the medical process gets performed.

Whereas the medical goal is the primary one in the gynaecological exam, the additional goal of preserving one's face needs (Brown & Levinson, 1987; Goffman, 1959, 1967, 1971) is uniquely experienced in this exam. Any medical examination is potentially threatening to patients' rights to privacy since the requirement to undress and to allow our body parts to be examined is generally proscribed in Western culture, *except* in the situations of lovemaking or a medical examination. The gynaecological exam poses special threats to both patient and practitioner, both because of the parts of the body to be examined and the positioning of the body necessary for the examination. The medical education litera-

ture, in fact, reveals that the pelvic exam is perceived negatively by patients and medical practitioners alike.

Research findings in medical education and women's health journals indicate that pelvic exams are abhorred by a great number of women (Domar, 1985/86), that such exams are dreaded, postponed, and seen as emotionally if not physically traumatising (Olson, 1981). One study (Weiss & Meadow, 1979) showed that 85% of female subjects reported negative feelings about their last pelvic exam, including descriptions of anxiety, vulnerability, humiliation, and dehumanisation. According to Domar (1985/86:75), 'the pelvic exam is one of the most common anxiety-producing medical procedures; it is certainly physically uncomfortable, embarrassing for some, and the nature of the lithotomy position strikes directly against traditional values such as modesty and respectability'. Alexander & McCullough discuss the exam as 'an extreme invasion of personal space' (1981: 123); Debrovner & Shubin-Stein (1975) found that women rarely overcome feelings of personal intrusion during a pelvic exam, regardless of how many prior exams they have experienced.

Leserman & Luke (1982) reiterate that the cultural taboos associated with female genitalia make the teaching of the exam problematic as well. Traditional pelvic teaching techniques (generally incorporating the use of plastic, facsimile models instead of live patients) have not been designed to alleviate medical students' fears and anxieties about performing the exam, including fear of hurting the patient, sexual arousal, being judged inept and finding the exam unpleasant (Leserman & Luke, 1982). Apparently, practitioners' fears and anxieties about the pelvic exam continue past medical school training, as at least two studies have shown that physicians neglect the pelvic examination altogether in their conducting of a complete physical exam (Mudd & Fleiss, 1973; Balk, Dreyfus, & Harris, 1982). Tunnadine (1980) reports that other physicians have found ways to objectively conduct the exam, to dismiss emotions of embarrassment, pain, or sexual conflict by ritualising the exam into a clinical encounter which avoids emotional or sexual awareness.

Emerson (1970) in her classic ethnographic study of the gynaecological exam discusses it as a precarious event in the sense that the exam must simultaneously sustain several contradictory definitions of reality. While she refers to these realities as the 'medical context' of the exam (i.e. treating the patient as technical object) and its 'counterdefinitions', (i.e. treating the patient as person and the pelvic area as different from other parts of the body in a physical exam), one could easily substitute 'medical goals' and 'face-preserving goals' for 'medical context' and 'counterdefinitions'. She explains that the patient must both be treated as technical object and simultaneously acknowledged as person in order to sustain the balance between medical and social goals.

The Gynaecological Exam as a Face-Threatening Act

It is apparent from the review of medical education literature that the gynaecological exam is uniquely anxiety-provoking to both participants. Whereas the need to preserve and maintain both one's own and one's partner's face in

interaction has been widely discussed (Goffman, 1959; Brown & Levinson, 1987), the goal of face-protecting is particularly felt in a procedure which possibly is seen by both interactants as invasive, intruding on one's personal space and privacy, and culturally taboo.

Brown & Levinson (1987: 65) discuss face-threatening acts as those verbal or non-verbal acts that intrinsically threaten face, 'those acts that by their nature run contrary to the face wants of the addressee and/or of the speaker'. Since the avoidance of embarrassment, humiliation, and 'emotional leakage' are seen as basic positive-face wants, the gynaecological exam can be viewed as a face-threatening act (FTA) to both patient and practitioner alike.

Brown & Levinson (1987: 68) point out that rational actors will seek to avoid or minimise FTAs in the context of the mutual vulnerability of face, taking into account three wants: '(a) the want to communicate the content of the FTA x, (b) the want to be efficient or urgent, and (c) the want to maintain H's (Hearer's) face to any degree.' Only if (b) is greater than (c) will the actor not wish to minimise the threat of his/her FTA. In the gynaecological exam, all of these wants are, apparently, in tension: the FTA (the medical exam itself) must be performed; the exam must be performed efficiently; and yet the face-wants of both interactants must also be served insofar as possible, contingent of course on the importance which both practitioners and patients place on the need to attend to the non-medical, personal goals of the exam.

While the literature on multiple goals, face needs, and the gynaecological exam *presumes* a priori the existence of multiple goals for rational actors, do participants actually *demonstrate* an orientation to these multiple goals in their conversational practices? Further, if the gynaecological exam is a FTA with the attendant medical goal of an efficient examination and the simultaneous face-goals of minimising face threats for the participants, how do interactants accomplish these mutual, and perhaps competing, goals? This study proposes that the examination of naturally occurring discourse displays participants' orientation to multiple goals in the gynaecological exam through their mutual construction of verbal play. It suggests further that these episodes of play may function to ameliorate the tension between medical and face goals of the exam.

Humour, Laughter and Play in the Medical Context

Humour is rarely mentioned as characterising physician–patient communication. In fact, few studies of medical communication have investigated humour or laughter. West (1984b: 126) reports that the dearth of laughter in the 21 doctor–patient encounters she analysed suggests that 'doctor–patient talk contains few "laughing matters"'. Communication scholars who have looked at the interpersonal dimensions of health care communication discuss composure, immediacy, formality, receptivity, and similarity (Burgoon, Pfau, Parrott, Birk, Coker & Burgoon, 1987) but do not focus on humour as a perceived feature of the interpersonal relationship between doctor and patient.

The absence of laughter in physician–*female* patient interaction may be even more pronounced, according to the literature. Most researchers who have studied

the gynaecological exam context refer only to its absence. The flavour of physician–patient interaction as reported by Todd (1984: 194), for example, suggests that laughter would be a scarce conversational resource:

Dr Masters: Okay, now, honey, look, so that you don't get pregnant again, I want you to get this foam, okay?
Patient: Um hm.
Dr Masters: You go to the drugstore and get it, and then here are the instructions. Read it. Now it's very simple.

(The female patient, notes Todd, has not been pregnant recently. Hence the physician's tone appears patronising and humourless in this context.)

When humour *is* attempted between male physician and female patient, reports of its occurrence display physician control and interaction asymmetry. Emerson (1970: 89) cites the following encounter:

'. . . a patient vehemently protests, "Oh, Dr. Raleigh, what are you doing?" Dr. Raleigh, exaggerating his southern accent, answers, "Nothin". His levity conveys: "However much you may dislike this, we have to go on with it for your own good. Since you know that perfectly well, your protest could not be calling for a serious answer".'

In West's (1984b) analysis of laughter in physician–patient conversations, more instances of invitations to laugh were declined than accepted (see Jefferson, 1979), both by doctor and by patient; however, this pattern was markedly asymmetrical in that doctors joined in patient-initiated laughter far less often than patients joined in doctor-initiated laughter. Laughter was hardly a shared phenomenon, leading West to suggest that laughter ironically contributed to interaction asymmetry in doctor–patient talk rather than to relieving tension and reducing social distance. Humour appears neither a frequent nor a collaborative feature of most medical communication. Such is not the case in the data analysed for the present study in which shared laughter and mutually achieved verbal play appear important features of the interaction.

Data Gathering and Analysis

Female students, faculty, and staff at a large, southwestern university in the USA participated in this study based on their requests for contraception and/or annual gynaecological exams at the campus health center. The university health center employs a female nurse practitioner (LNP) who is licensed by the state to perform the majority of routine gynaecological examinations and to do contraceptive counselling.

All women patients were asked to read a release form which explained the research project and to verbally signal their consent to participate in the study (i.e. to allow their interactions with the LNP to be audio-taped).[2] The university's institutional Review Board required that verbal rather than written consent be obtained in order to protect the patients' anonymity. A total of 56 women ranging in age from 18 to 33 (93% of the 60 women requesting contraception and/or gynaecological exams) agreed to participate in the study over a three month

period in the spring of 1986. Due to a mechanical error in recording, only 41 of the 56 interactions were recorded in their entirety. The data, therefore, consist of these 41 tape-recorded interactions.

Audio-taped recordings were made of the gynaecological interactions with the aid of a microphone that was suspended from the ceiling over the exam table. The recorded conversations were transcribed so that interactants' talk could be analysed, using the conversation analytic methods of Sacks, Schegloff, Jefferson, Pomerantz, West, Frankel, and others. Transcriptions in the text of this paper utilise the transcribing conventions of Jefferson as reported in Atkinson & Heritage (1984).

Given the extant discourse analytic literature on interaction between women patients and health care practitioners (Todd, 1983, 1984; West, 1984a, 1984b), interaction which is reported to be largely devoid both of social discourse and of laughter, it was notable to hear in all 41 LNP–patient conversations an abundance of non-medical talk — e.g. shared stories, personal disclosures, and the like. A striking feature of the talk, again given expectations based on previous literature, was the presence of shared laughter in all but three of the exam interactions.

Not only did shared laughter occur in the tapes collected for this study; patient and LNP occasionally joked or teased, engaging in which could be seen as verbal play. 15 instances of verbal play in 15 different interactions were transcribed; 12 of these are analysed in the current report.

Recognising Play Sequences

Unlike the research procedures of Glenn's and Knapp's study of play (1987), in which couples were instructed *post hoc* to identify segments of play from videotapes of their interactions, the researchers in the present study could use only auditory cues to isolate verbal play sequences. Shared laughter and exaggerated vocal intonation were the most frequently relied upon cues signalling the occurrence of play. But as Hopper (1987) notes in his examination of laughter and verbal imitation as play cues, both interactants must cooperate to construct the play frame. It is not one speaker's laughter, another's incongruous or absurd statement, or the first speaker's exaggerated vocal emphasis that specifically cue the frame 'this is play'; rather play is interactively achieved by participants. The distinction between shared laughter, joking/teasing, and verbal play is an important one. Whereas shared laughter is a probable indicator of play (see Glenn & Knapp, 1987; Hopper, 1987), it does not appear a sufficient demonstrator that participants are engaged in playful action in the data analysed for this study. In the following excerpt, for example, shared laughter occurs in lines 5 and 6, yet playful action in the sense of Bateson's (1972) and Goffman's (1974) notion of play does not.

Extract (2)

1 **LNP:** Well if you can remember to keep your tummy muscles
2 relaxed and your thigh muscles as relaxed as possible

3 it's real hard to do when especially when you're (.hhh)
4 uptight=
→ 5 **P:** =Well isn't everybody? heh heh heh
→ 6 **LNP:** heh heh uh yeah (.hhh) but you know if you tighten those up
7 it tightens up your vaginal muscles okay?
8 **P:** Um hm.

Play as a collaboratively achieved feature of talk requires both invitation to play and uptake, i.e. a response that appreciates or extends the other's attempt at levity. Thus, while shared laughter and exaggerated intonation were cues signalling the possibility of play, a conversational sequence was not designated as play for this analysis unless both participants displayed an orientation to the conversation as 'being engaged in playful activity'.

The remainder of this essay will explore these collaboratively designed instances of verbal play and will discuss ways in which play sequences in the gynaecological interaction surface the non-medical goals of recognising practitioner and patient as persons (rather than as technician and technical object) and redressing the FTA of the exam, thus serving mutual positive-face goals of participants. First the exam environment in which play sequences are embedded warrants description.

The Interaction Context of Play

The play described in this study takes the form of a humourous side sequence (Jefferson, 1972) embedded within the exam activity itself. Since there is no video record of the exam, it is not possible to ascertain whether the nonverbal procedures of the exam stop for verbal play. The transcripts, however, suggest that the medical procedure is ongoing in that the LNP directly comments on it, as in these extracts:

Extract (3)

1 **LNP:** have have you noticed after you've been on the pills that your
2 periods are don't last as long or are they shorter or=
3 **P:** =yes they are shorter
(8.5)
4 **LNP:** It's a lot nicer havin' em for a shorter length of time isn't it
5 heh heh heh
[ ]
6 **P:** heh heh yes it is
7 **LNP:** (bet) you can tell just like clockwork too when you have your
8 periods can't ya?
9 **P:** Um hm.
10 **LNP:** plan holidays around them heh heh heh
[ ]
11 **P:** heh heh heh=

→ 12 **LNP:** =(vacations) no abnormal tenderness in here is there
14 **P:** No

Extract (4)

1 **LNP:** I can always tell when I drink too much coffee. I get irri-
2 tated and I have to eliminate more frequently
[ ]
3 **P:** Do you? hm
4 **LNP:** So it definitely does have (an effect)
[ ]
5 **P:** I don't have coffee (addiction) I'm
6 glad=
7 **LNP:** =I definitely have a coffee addiction
[ ]
8 **P:** heh heh heh I'm not interested in
9 it at all: it tastes terrible=
→ 10 **LNP:** =now I'm gonna check the outside of your vaginal area first
11 okay=
12 **P:** =okay=
13 **LNP:** =what I'm checking for is any abnormal discharge or lumps or
14 masses that you might not be aware of.

Play sequences are embedded within the exam procedures. More interesting is the sequential environment in which play occurs. In all 41 gynaecological exams, medical format consisted of this invariant sequencing of events: explanation of procedures and lab tests to be run; breast exam; pelvic exam; and contraceptive fitting or prescription. In 13 of 15 instances, play sequences were located in talk immediately before, during, or after the pelvic examination itself. One would speculate the pelvic exam to be the place in the gynaecological exam at which face threats to both practitioner and patient are severe, due to the invasive procedure of the internal examination and the attendant possibilities of mutual embarrassment and awkwardness.

Frankel (1983: 44) reports on the use of questions by pediatricians in examining their young patients; through videotape, he demonstrates that questions 'direct the visual attention of the patient away from the work of the hands and to the task of conversing'. While videotaping was proscribed in the gynaecological exam context, one assumes that verbal play might function similarly to questions in Frankel's study: in the part of the exam that is most threatening to medical personnel and patient alike, laughter might well be directing the patient's as well as the medical caregiver's focus away from any uncomfortable aspects of the exam process. This appears plausible, even though, ironically, the topic of humour is often the exam process itself. Jointly produced verbal play may function to move participants to a level of interacting that redresses the potential face threat of the exam.

A frequent feature of the talk in which play is embedded is a pause — sometimes lengthy — immediately preceding the onset of play, as these fragments show:

Extract (5)

1 **LNP:** Are you doin' okay?
2 **P:** he heh heh alright yeah::
→ (2.7)
→ 3 **LNP:** NOT always the best thing to do is it
4 **P:** heh heh heh (a little)
[ ]
5 **LNP:** NEVER (just the) thing to spend your afternoon
[ ] [ ]
6 **P:** heh heh heh heh he heh
7 I can think of a lot of other things heh heh heh
[ ]
8 **LNP:** heh heh heh oh yes::
9 Definitely=
10 **P:** =heh heh heh heh.

Extract (6)

1 **P:** oh little socks on it how nice hemh hemh hemh hemh
2 **LNP:** a lot better than cold steel
3 **P:** oh yeah: really::
(2.4)
4 **LNP:** Scoot all the way down here.
5 **P:** Okay.
→ (4.8)
→ 6 **LNP:** (See I jus' think) they oughtta put these little messages on the
7 ceiling here ( )
[ ]
8 **P:** Um hm?
9 **LNP:** I'm all for it (you know) (pictures) of naked men up
(figures)
10 there
[ ]
11 **P:** heh heh heh heh Think think they oughtta do something like that
12 **LNP:** I got my priorities.
13 **P:** Really.

Extract (7)

→ (14.5)
→ 1 **LNP:** Is it pretty outside?
2 **P:** It's gorgeous=

3 **LNP:** =ha ha ha ha you could have lied.
4 **P:** It's kind of windy but other than that it's pretty nice
5 **LNP:** You could have lied ha ha
[ ]
6 **P:** heh heh heh=
7 **LNP:** =I haven't been out since six o'clock this morning
8 **P:** Alright it's really windy and it's really terrible I mean=
[ ]
9 **LNP:** THANK YOU!
10 **P:** =horrible! heh heh heh heh
[
11 **LNP:** ha ha you love every minute of it
12 **P:** ha ha ha heh heh=
13 **LNP:** =let your knees kinda fall to side there you go (0.5) okay no
14 problems with abnormal discharge or itching in your genital
15 area?

Again, without benefit of video record, there is no way to detect what nonverbal activity may occasion the beginnings of verbal play; yet in each of the above, play commences after the pause and either during (Extract 5) or immediately before the pelvic exam begins (Extracts 6 and 7). In Extract 5, the context preceding line 1 is that the LNP has begun the pelvic exam — hence her remark in line 1, 'Are you doin' okay?'; in (6) she is readying the patient physically for the exam in her instruction in line 4, 'Scoot all the way down here', and in (7) it is probable that the patient is physically readying herself for the exam as the LNP instructs in line 13, 'let your knees kinda fall to side'. Thus, both the sequencing of verbal play — either before, during, or after the pelvic exam — and the pause in the interaction sequence which immediately precedes its onset suggest that patient and practitioner orient to the situation of the pelvic exam as face-threatening, and attempt through levity to redress its impact. The specific ways in which verbal play evidences this redressing, while also acknowledging the personal identities of the interactants, is explicated in the section to follow.

Analysis of Play Sequences

Brown & Levinson (1987) discuss redressive action as attempts to counteract the potential face damage of FTA by indicating that no face threat is intended or desired. Positive politeness is redress that appreciates the wants of the interactants in general or expresses similarity between interactants' wants through three broad strategies: claiming common ground; conveying that interactants are cooperators; and actually fulfilling interactants' wants. In the play sequences analysed for this report, shared humour hinges on commonality and cooperation. The invitation to play and its uptake display participant recognition of a shared background of values and beliefs; i.e. the very occurrence of play is contingent

upon interactants' common attitudes about gynaecology and the gynaecological exam, as displayed in the following extracts:

Extract (8)

1 **LNP:** All done: (2.4) that's it:
(3.5)
2 **P:** (hhh) Gee that was fun.
[ ]
3 **LNP:** heh heh heh heh heh
[ ]
4 **P:** heh heh heh heh heh heh heh
(1.2)
5 **LNP:** oh you wanna do it again? heh heh heh=
6 **P:** =heh heh heh
7 **LNP:** Okay so I'll run all this stuff to the lab.

Extract (9)

1 **LNP:** Do you usually wear tampons or pads=
2 **P:** =usually always tampons until it's over with because I hate pads.
4 **LNP:** uh hum.
5 **P:** I mean I hate this part of being a girl in fact heh heh heh=
6 **LNP:** =heh heh heh heh DON'T LIKE THIS AT ALL:::=
7 **P:** =heh heh heh I uh=
8 **LNP:** =if you're going to wear tampons change them every two hours
9 and also um make sure they're not the deodorant kind.

In Extracts (8) above and (5) (see page 69), humour revolves around the held-in-common cultural belief that the gynaecological exam is an unpleasant experience, at least for the patient. In (8) the nurse has just concluded the pelvic exam and announces in line 1 that it's 'all done'. Her laughter following the patient's 'Gee that was fun' in line 2 displays recognition of the ironic intent of the comment, recognising if not corroborating the patient's attitude that pelvic exams could *not* be fun. The patient's shared laugher at line 4 validates this interpretation, as does the nurse's returned facetious question — 'Oh you wanna do it again?' — at line 5. Similarly in (5), during the course of the pelvic exam, the nurse comments that the exam is 'not always the best thing to do is it' — both the humorous understatement of the comment and the tag question display that the nurse presumes that the patient does not find the exam pleasant. The patient again validates this presumption with laughter at lines 4 and 6, and both nurse and patient collaborate in lines 5–10 to expand the understatement that there are definitely more pleasant ways to spend one's afternoon than participating in a pelvic exam. These play sequences reduce the face-threat of the exam in that the nurse presumes an understanding of the patient's dislike of the exam and the patient corroborates to validate her perspective — thus, play produces a shared, mutually constructed definition of the situation.

In Extracts (3) (see page 73) and (9) above, the nurse again employs a cooperative strategy (Brown & Levinson, 1987) in assuming a knowledge of the patient's attitudes toward menstruation. In (3), humour rests on the nurse's presumption that the patient appreciates the shorter, more regular periods that are side effects of the birth control pill. In a series of questions extolling these virtues of the pill to the patient, the nurse humorously points out at line 10 that the patient can even 'plan holidays' around her periods. Again, the tag questions at lines 4, 7 and 12 invite the patient into conversation while also presuming knowledge of her attitudes. The patient validates the playfulness of the sequence through her laughter at lines 6 and 11; she also validates the nurse's presumption that she prefers shorter periods by agreeing with this assertion in line 6.

Extract (9) is curious in that the nurse in line 6 appears to mock the patient's attitudes toward her periods. Whereas this remark might enhance rather than redress face threat, there are several conversational features that frame the nurse's teasing remark as humorous rather than as inappropriate/untoward. First, the patient invites the nurse's laughter with her post-utterance laughter in line 5 after acknowledging, 'I hate this part of being a girl', to which the nurse responds with laughter and an exaggerated restatement — 'Don't like this at all' — in line 6. But, in addition, the nurse's tease displays understanding and humorous appreciation of the patient's attitude, such understanding made possible by the commonly held cultural belief that menstruation is, at best, a nuisance.

In another instance, the nurse compares her dispensing of contraceptive pill packets (line 1) to giving a 'graduation present' (line 3). That the patient responds to this with laughter and an appreciation component — 'much needed' — in line 4 confirms the nurse's presumption that the patient recognises and appreciates the gift analogy, thus evidencing a shared belief about the pill. The nurse extends the play in lines 5–6, 8, and 12 by presuming that the patient's boyfriend, too, will appreciate this 'gift' and that she should be voted 'the most popular woman on campus' — remarks that otherwise could be seen as inappropriately intimate and intrusive. The patient's laughter in lines 9, 11, and 13 displays agreement with the nurse's exaggerated self-appreciation, such agreement evidencing that the nurse has correctly assessed the patient's attitude about the pill. This sequence thus produces solidarity by showing nurse and patient to hold in common the belief that the contraceptive pill is valued in the patient's sexual relationship.

Extract (10)

1 **LNP:** So this would be like May June July ( )=
[ ]
2 **P:** Okay great thanks:
3 **LNP:** =graduation present=
4 **P:** =heh heh heh much: needed=
5 **LNP:** =Much: needed:: present yes you and your boyfriend will
6 appreciate it?
[ ]
7 **P:** heh heh heh

8 **LNP:** I should be voted the most popular woman=
[
9 **P:** heh heh heh heh
10 **LNP:** =on campus=
11 **P:** heh heh heh heh
[ ]
12 **LNP:** heh heh heh most appreciated. They just don't know it.=
13 **P:** =heh heh heh=
14 **LNP:** so if you have any problems come on back down=
15 **P:** =okay.

Still other instances of verbal play display in-group membership, another strategy that claims common ground and thus helps redress potential face-threat (Brown & Levinson, 1987). In Extract (6) (earlier), the nurse's invitation to play at lines 6–7 and line 9 cast her as a member of the same group as the patient in wanting pictures of naked men on the ceiling above the examining table. The patient's appreciation of this levity at line 11 corroborates the nurse's perspective. Both the invitation to play and the uptake (line 11) display that nurse and patient hold in common certain views about the exam and about the out-group — men. Play thus serves a solidarity goal in this instance.

Similarly, in Extract 11, play revolves around the nurse's admission that she, too, is a member of that group of 'girls' who sit under a sun lamp to get a tan. The nurse's question 'have you been sitting under a sun lamp?' in line 3 could again be seen as inappropriately intimate and face-threatening since she is commenting on non-medical aspects of the patient's naked body, yet the ensuing conversation counters this interpretation. The patient's confirmation and laughter in line 4 is greeted with laughter by the nurse in line 5 and further 'confession' by the patient in line 6 — at this point, the humour seems to rest only in the nurse's 'discovery' of the patient's tan and the patient's admission of its source. In lines 7–8, however, the nurse finally 'confesses' that she, too, has been tanning under a sun lamp — not only does this self-disclosure achieve solidarity between the two as members belonging to the group of sun-lamp tanners; it also establishes the nurse as a person outside her technical role as examiner. Likewise, the nurse's potentially face-threatening question in line 3 is apparently interpreted by the patient as acknowledgment of her as a person with a life outside the medical context, thus possibly reducing the face threat of the awkward physical act of 'scooting to the head of the table' after the pelvic exam.

Extract (11)

1 **LNP:** Okay everything feels fine (.) go ahead and scoot to the head of
2 the table a little bit I don't wanna lose you off the edge here.
3 (0.5) have you been sitting under a sun lamp?
4 **P:** some heh heh heh heh
[ ]

5 **LNP:** ha ha you can always tell the girls who
( )
[ ]
6 **P:** ha ha ha ha I don't admit it to most people ( )
[ ]
7 **LNP:** ha ha 'at's okay.
8 I've been doin' it too so I ( )=
[ ]
9 **P:** ha ha ha ha
10 **LNP:** =um if anything like I said abnormal shows up I'll be sure to let
11 you know.

In the next instance, verbal play displays nurse and patient as members of a group who are familiar with the Dracula legend, but who also, and more intimately, find feminine odour a topic of shared humour.

Extract (12)

1 **P:** Well I've even heard to take a clove of garlic for yeast infec-
2 tions a clove of garlic and wrap it in=
[ ]
3 **LNP:** No
4 **P:** =I've never tried it though
5 **LNP:** I don't think I would try it because=
6 **P:** =but I mean I heard all sorts of weird things but that actually
7 that was in Our Bodies Ourselves I think that's where I got it
8 from.
9 **LNP:** Was it?
10 **P:** A clove of garlic um hum but I think I did read something about
11 the um baking soda water
12 **LNP:** One thing I can think of with the clove of garlic is your mucus
13 membranes absorb the um you know the odour so uh heh heh heh
P: [ ]
14 ha ha ha ha
15 ha ha heh heh heh that would definitely keep Dracula away=
16 **LNP:** Especially for that area you know ha ha ha you don't have to
17 worry about that area at all um what I'll do is go ahead and go
18 **LNP:** around and get a prescription signed for you.
19 **P:** Okay.

In lines 1–11, the patient discusses a folk remedy for curing yeast infections with a clove of garlic. At line 12, the nurse invites play by switching from the patient's medical talk to humorous speculation about vaginal odour that would ensue if one placed garlic in 'that area'. The patient responds with shared laughter at lines 14 and 15, extending the levity by invoking the Dracula legend. The nurse's appreciation in lines 16 and 17 corroborates the shared female experience of both realis-

ing and making light of the cultural taboo of vaginal odour. Both the intimate topic of play and the in-common social knowledge of these women promote solidarity between them.

Some Comments on the Bonding Function of Play

Play by its very nature is created interactively (Bateson, 1972; Gleen & Knapp, 1987; Goffman, 1974; Hopper, 1987). In fact, the conversational design of play is an invitation to play, followed by a response/uptake that signifies that the second speaker recognises and validates the preceding utterance as humorous. If we were to conceptualise verbal play as one or more sequences of adjacency pairs, we would discover the pattern of invitation/acceptance; further expansion of play/acceptance, and so forth. That the acceptance of a play invitation is a requisite of play facilitates social solidarity between players. Perhaps that is why the literature on play abounds with testimony of its positive function in intimate relationships in enhancing communication, generating bonds, reducing tension and helping to moderate conflict (Betcher, 1981). Glenn & Knapp (1987: 50) in summarising the functions of play assert: 'Play seems to be an important act in preserving both individual and relational equilibrium'. As an interactive, cooperative, relational phenomenom, play intrinsically recognises the other as worthy of engaging in play with, hence, its unique bonding potential.

In the date analysed for this study, the face-threat of the gynaecological exam occasions levity, which becomes verbal play when the other interactant displays recognition and acceptance of the play invitation. Since play is interactively constructed around shared attitudes and common in-group membership, it redresses the face-threat of the exam as well as acknowledges the practitioner and patient as more than mere technician and technical object. That play is a necessarily collaborative phenomenon serves the positive face-goals of both participants: Inviting and accepting play are acts which recognise the other's face needs; moreover, the mutual construction of play expresses the message, 'we're cooperating in this — play *and* exam — together'. Whereas humour, joking, or teasing can be achieved at the expense of the other, play enhances both self *and* other — hence its interpersonal value. Thus, in the gynaecological exam context, verbal play accomplishes the multiple goals of personally recognising both practitioner and patient as well as reducing the face-threat of the exam. Moreover, since play can be conducted concurrently with the examining process, it also facilitates rather than disrupts the medical goal of the exam, similarly to the way in which touch facilitates the pediatric exam (Frankel, 1983). Play then serves to mitigate the intrinsic conflict between medical and face goals in the gynaecological exam.

Conclusion

The multiple goals literature suggests that rational actors attend both to task and face goals in their discourse, strategically structuring discourse to attain these goals. This analysis of verbal play suggests that it may also be useful to begin with

discourse itself in examining multiple goals. Discourse and conversation analysis provide the methodological advantage of permitting the data to actually display participants' awareness of and orientation to interaction goals. That practitioner and patient engaged in verbal play during the most precarious moments of the gynaecological exam evidences the goals of mutual face-preserving and social bonding in the context of a mutually face-threatening act. Naturally occurring conversation grants access to the conversational practices whereby which interactants both generate and achieve multiple goals.

On a more pragmatic level, this study raises the question of whether verbal play is perceived by interactants as redressing a potentially face-threatening act, both in the gynaecological exam and, possibly, in other contexts as well. Brown's & Levinson's (1987) politeness theory would suggest so, but participants' perspectives also could enhance our assessment of the value of play as a social bonding/solidarity strategy in non-intimate as well as intimate relationships. Of course, it must be emphasised that the play analysed for this report consisted of play between women who were engaged in a procedure for women. In fact, much of the verbal play described in this report could be enacted *only* between women since the topics of humour revolved around women's uniquely shared attitudes and experiences. It would be interesting to note the conversational consequences in the gynaecological exam, for example, if either male practitioner or a female patient being examined by him, attempted levity around the subject of the exam's unpleasantness. Shared gender might prove a critical component of the efficacy of play in serving participants' face needs, at least in some contexts.

The co-construction of play in the exam sequences also raises questions about social status and play: does play get enacted only when status differences outside its context yield to egalitarianism within? When participants engage in play, do they necessarily leave their social/professional roles outside its frame? Other studies of verbal play have looked at peers in non-professional contexts (Glenn & Knapp, 1987; Hopper, 1987; Labov, 1972). In the current study, role differences certainly exist, yet they are not so profound as those in Todd's, West's, or Emerson's physician–patient conversations, in which humorous episodes either did not exist or else took a very different, asymmetrical shape. Do the willingness to play and the occurrence of play serve as levellers, momentarily obscuring status asymmetry? If so, then play may function in many professinal contexts in which it is necessary to display technical competence while also affirming personal and face goals; i.e. play may help link the multiple, antithetical goals of our high-tech/high-touch society. The paradox, of course, is that the accomplishments of play are largely unintentional. Play cannot be strategically planned; its very nature suggests that an instruction to 'do play' would constitute a double bind of the same order as 'be spontaneous'. Thus, verbal play will hardly get incorporated into corporate manuals as a management tactic — a boon to those of us who appreciate its art and its mystery.

Notes

1. The author wishes to thank Michael Pagano for his assistance in data collection and Phil Glenn, Karen Tracy, Nikolas Coupland, and Anita Pomerantz for their helpful suggestions in data analysis.
2. The preferred research design would be to both audio- and video-tape the gynaecological exam interactions; however, the unique nature of this medical interaction naturally precluded our attaining permission to use a video camera. It is unfortunate, therefore, that we were unable to make a video record of the interactions and to coordinate verbal with nonverbal communication in the exam procedures. That lengthy silences in conversation were found immediately preceding the onset of verbal play sequences (as described on pages 12–13) makes the lack of a video record particularly felt. Nonverbal interaction accompanying those silences no doubt would provide rich clues as to what sort of events precipitate and signal the beginning of play.

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