

# Heteronormativity in Action: Reproducing the Heterosexual Nuclear Family in After-hours Medical Calls

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*Heterosexism has become a recognized social problem since the rise of lesbian, gay, bisexual, and transgender (LGBT) activism in the 1970s. One of its manifestations is heteronormativity: the mundane production of heterosexuality as the normal, natural, taken-for-granted sexuality. My research uses conversation analysis to explore heteronormativity as an ongoing, situated, practical accomplishment by people oriented to other actions entirely. I show that family reference terms—across a dataset of 59 after-hours calls to the doctor—are deployed so as to construct a normative version of the heterosexual nuclear family: a married couple, co-resident with their biological, dependent children. I examine the inferences normatively attached to family reference terms, consider how these inferences are used interactionally, and document how this everyday talk-in-interaction both reflects and reconstitutes the culturally normative definition of the family. This research advances our understanding of normativity by showing how a social problem can exist even when there is no orientation to “trouble” in interaction. Here, the persistent and untroubled reproduction of a taken-for-granted heteronormative world both reflects heterosexual privilege and (by extrapolation) perpetuates the oppression of non-heterosexual people, denied access to key social institutions such as marriage and unable to take for granted access to their culture’s family reference terms. The article shows how the heteronormative social order is reproduced at the level of mundane social interaction, through the everyday conversational practices of ordinary folk.*

One of the major achievements of the lesbian, gay, bisexual and transgender (LGBT) movements of the last 30 years has been to transform—at least in many quarters—“the problem of homosexuality” into “the problem of heterosexism.” So, for example, the focus of social scientific research has shifted from a focus on LGBT people *per se* (e.g., assessing their mental health or their parenting capacities) to the multiple oppressions to which they are subjected—ranging from state-sanctioned execution, torture, and enforced psychiatric treatment (Amnesty International 2001), to institutional discrimination and hate crimes (Herek and Berrill 1991), to the mundane oppressions of everyday life, such as anti-gay jokes and the social gaffes made by well-meaning heterosexuals in talking to, or about, LGBT people (Conley et al. 2002).

Just as “homosexuality” is a social construction invented to diagnose, circumscribe, and control certain kinds of behavior (same-sex sexual relationships) treated as social problems (Kitzinger 1987), so too is “heterosexism” such a social construction. The term represents a second attempt by the LGBT movement (the first was “homophobia”; see Kitzinger 1987) to label certain kinds of behavior (e.g., discrimination, prejudice, and violence against LGBT people) as social problems. Insofar as the social construction of “heterosexism” is successful, it

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is the behavior of heterosexual people in discriminating against LGBT people that is the legitimate target of social reform. As a social constructionist, one approach I might take to “heterosexism” as a topic (not the one pursued here) would be to investigate how (i.e., through what claims-making actions, with what degree of success, and against what contestations) the LGBT movements have struggled to promote heterosexism as a social problem. An alternative approach—the one exemplified here—is to explore how everyday heterosexist reality is constructed: that is, how does it come about that people in ordinary interactions (not motivated by heterosexist prejudice or discriminatory intent) commonly invoke and produce a normative heterosexual world as a taken-for-granted reality?

As a lesbian-feminist activist and scholar, I am concerned about the full spectrum of heterosexist oppression—from the deportation of homosexual asylum seekers to countries in which they are tortured and imprisoned, to the denial of equal marriage rights to same-sex couples, to the minor indignities and exclusions of everyday life. The analysis presented here aims to gain purchase on the latter phenomenon. It is motivated by my strong sense that while LGBT activists are campaigning against blatant oppression and overt discrimination, at the same time all around us a heteronormative social fabric is unobtrusively rewoven, thread by thread, persistently, without fuss or fanfare, without oppressive intent or conscious design. My current research program uses conversation analysis to explore how that is done and aims to understand what strong threads constitute and bind together a normative heterosexist culture that make it so impervious to challenge and so slow to change. In this study, my aim is to make visible (and thereby to enable us all to challenge) some of the mundane quotidian actions that result in the routine achievement of a taken-for-granted world that socially excludes or marginalizes non-heterosexuals.

The term “heteronormativity” is widely used in contemporary political, social, and critical theory to describe socio-legal (e.g., Phelan 2001), cultural (e.g., Lancaster 2003), organizational (e.g., Grace 1999), and interpersonal (e.g., Blasius 2000) practices that derive from and reinforce a set of taken-for-granted presumptions relating to sex and gender. These include the presumptions that there are only two sexes; that it is “normal” or “natural” for people of different sexes to be attracted to one another; that these attractions may be publicly displayed and celebrated; that social institutions such as marriage and the family are appropriately organized around different-sex pairings; that same-sex couples are (if not “deviant”) a “variation on” or an “alternative to” the heterosexual couple. Heteronormativity refers, in sum, to the myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted, ordinary phenomenon.

In contrast with what John Heritage (1984) calls the “normative determinism” (p. 16) of theorists such as Durkheim, Freud, and Parsons, the conversation analytic approach pursued here (like ethnomethodology more generally; Garfinkel 1967) does not depend upon an understanding of actors as the bearers of internalized, culturally transmitted norms that guide or determine their conduct. Heteronormativity is embodied in what people do rather than in their beliefs, values, ideologies, or faiths. Complicity with heteronormativity does not necessarily imply prejudiced attitudes or beliefs (e.g., as these are usually conceptualized by homophobia scales; see Kitzinger 1987) or any deliberate intent to discriminate against LGBT people (Kitzinger forthcoming). Rather, heteronormativity—like other social norms—is embodied and displayed endogenously, in the details of conduct, and may be studied empirically as such.

My empirical investigation of heteronormativity builds on Harvey Sacks’s (1995a) analysis of norms,<sup>1</sup> most especially in relation to membership categorization as outlined in his

1. As Sacks (1995a) points out, his is “a different sense of ‘norms regulating activities’ than one might usually use in doing sociology or anthropology, where it would be said by and large that the norms are followed by those persons who do the things—or ought to be” (p. 253). Although norms and normativity (as here defined) are central to conversation analysis as a field, few conversation analysts since Sacks have used this terminology in their work; but see

classic lecture “The Baby Cried. The Mommy Picked It Up.” Norms, according to Sacks (1995a), provide rules of relevance for selecting categories (“viewers use norms to provide the relevant membership categories in terms of which they formulate identifications of the doers of those activities for which the norms are appropriate”; p. 260), and people “use norms to provide some orderliness, and proper orderliness of the activities they observe” (p. 260). According to Sacks, norms are used to “see a family” when observers see a man beating up a woman and do nothing because “we thought you were married and it wasn’t any of our business” (p. 91). Also according to Sacks, people can “pass” as members of categories to which they do not in fact belong simply by virtue of the norm that leads them to be seen that way, as when “a woman walks away from a supermarket with the baby carriage filled with a baby that’s not hers” (p. 254). Norms might also occlude families as when older parents observed caring for their child are taken to be the child’s grandparents (p. 226), or as in the following account from the mother of two-year old Nathaniel, describing what happened when they were referred to a new doctor: “After I had introduced her to Nathaniel and explained his symptoms she responded by looking at me and asking, ‘And who are you?’ Since parents do not need to legitimate their right to discuss their own children’s illnesses with a doctor, I inferred from this that she did not think I could be his mother” (Liladhar 1999:240). Janine Liladhar (1999) understands the doctor’s displayed inference that she is not the mother of her child with reference to race: she is white and her son is black. Observers apparently did not see a family when a white mother playing race-you-to-the-car with her 20-year-old black son was taken to be pursuing a thief (Rosenblum and Travis 2000:169) or when two lesbian parents were asked, “which one of you is the mother” (Dalton and Bielby 2000). In such instances, other cultural norms (about “age,” “race,” and the proper gender constitution of family members) overturn inferences that could or should be made normatively on the basis of category-bound activities. Through the displayed assumptions of the interactants in such situations, analysts can begin to understand the constitution of the normative concept of the family as, for example, “private,” mono-racial, and bi-gendered.

The research reported here develops the Sacksian notion of norms with specific reference to the heterosexual nuclear family. It puts conduct in interaction at the center of theorizing about the social world, and shows how norms and normativity can be grounded and elaborated in detailed empirical analysis of their deployment in action. As such, it is part of the ethnomethodological tradition that aims to “treat the obvious as a phenomenon” (Zimmerman and Pollner 1970:80) and to explicate the seen-but-unnoticed tacit presuppositions (or “norms”) of everyday life and contributes thereby to the “sociology of the unmarked” (Brekhus 1998) an understanding of the practices that produce ordinary mundane heterosexism.

Insofar as conversation analysis has focused on social problems—and certainly in relation to the social problems highlighted in the 1988 special issue of *Social Problems* on “Language, Interaction, and Social Problems”—these have been treated in the form of “trouble” as oriented to by participants in interaction (Maynard 1988:325). However, from the point of view of many social activists, and others concerned with social problems—indeed, including Sacks, the founder of conversation analysis himself, in his early lectures (Sacks 1995b:175–87)—social problems can also be produced, and reproduced, by social actors who are not oriented to any trouble in their interactions. A social problem exists only for us, as analysts eavesdropping on their talk, who see in it the untroubled reproduction of a heterosexist (or racist or classist or otherwise oppressive) world. One important theoretical goal of this article, then, is to highlight the value of conversation analysis in analyzing interactions in which, by and large (and with orderly exceptions), the taken-for-granted, ordinary world is reproduced

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Schegloff’s analysis of *sotte voce* improprieties as episodes in which “formal notice is . . . taken of the cultural norms applicable here, in the very course of showing a lack of commitment to abide by them” (Schegloff 2003:63). Rather than abandoning important sociological notions such as norms and normativity, I am here respecifying them in terms used by ethnomethodologists and conversation analysts.

and reconstituted with no trouble at all—because it is precisely the assumptions with which this taken-for-granted world is imbued that cause “trouble” or “problems” (at best), and oppression and discrimination (at worst), for those who do not conform to its cultural norms.

### Family as a Categorization Device

This article focuses on person reference terms drawn from the category of the “family” as these are deployed by interactants in after-hours calls to a doctor. Previous analyses have shown that social participants readily produce family terminology that displays their heterosexuality without being heard thereby as doing anything out of the ordinary (Kitzinger 2005), whereas when people make it apparent in the course of ordinary activities (such as making a dentist appointment or taking out car insurance) that they have same-sex partners there are recurrent interactional problems (Land and Kitzinger 2005). The analysis presented here is particularly germane, then, to the sociological tradition of work on the family—long-considered a social problem, especially in its “deviant” forms: for example, black families (e.g., Stack 1974), or working-class families (e.g., Rubin 1976; compare to Smith 1993). LGBT families, in particular, are at the forefront of contemporary debates about marriage and the family (e.g., Bernstein and Reimann 2001; Weston 1998).

Family researchers have been preoccupied by issues of definition. As James A. Holstein and Jaber F. Gubrium (1999) argue, however, “family is not objectively meaningful . . . it is constantly under construction, obtaining its defining characteristics somewhere, somehow, in real time and place, through interpretive practice” (p. 4). This, they suggest, mandates an empirical focus on “the myriad social processes through which persons in the course of everyday life produce and organize ‘family’ as a meaningful designation for social relations” (p. 4). In common with their innovative empirical research program analyzing discourse about the family across a range of organizational contexts (e.g., Gubrium and Holstein 1990; Holstein 1993), the work to be reported here explores how “family” is constructed in interaction. The production of the heteronormative family is understood as an ongoing, locally managed accomplishment, and the analysis focuses on one of the key practices through which family is constituted in these calls: the use of person references and the inferences that attach to these.

Person references drawn from the category of “family”—such as “wife,” “husband,” “daughter,” “brother-in-law,” and so on—are common non-recognitional person references (Sacks 1963, 1972a; Sacks and Schegloff 1979; Schegloff 1996). That is, they are terms routinely deployed as references to third parties in talk-in-interaction where the speaker is treating their co-conversationalist as someone who does not know the person being referred to and/or would not recognize them by name. (Other examples of typical non-recognitional person references include categorical or role references such as “a doctor,” “an African-American,” “a diabetic,” “a woman.”) Family reference terms are among the categories whose deployment Sacks began to explore—most famously in “the baby cried, the mommy picked it up” discussion (Sacks 1972b, 1995a), but also at various points scattered throughout his work, including an interrogation of the use of inferences attached to “wife,” “sister,” and “child” in a counseling call (Sacks 1995a:116) and the (hypothetical) deployment of “heterosexual couple” inferences to disguise otherwise stigmatized identities (Sacks 1995a:593). The present research, then, builds on the early work by Sacks both on norms and on membership categories, and contributes to conversation analysis a more systematic and data-driven approach to the selection and deployment of non-recognitional person reference forms. It explores—in a single corpus of calls—the difference the selected person reference term makes to the sequence that subsequently unfolds, due to the inferences that, thereby, can be seen to attach to the term selected. I begin with a description of the dataset and then consider the way in which the talk produces a heteronormative version of family.

## Data

The data corpus comprises recordings of 59 after-hours calls made to a medical practice in a large town in the English Midlands.<sup>2</sup> In 50 of the 59 calls, the caller is someone other than the patient; these calls are the focus of analysis here. According to the terms of reference of the British National Health Service, general practitioners—physicians with no particular clinical specialization—have 24-hour responsibility for the medical care of their patients. This includes the condition that they should visit patients in their own homes if necessary, either because the patient cannot travel to the surgery or because the surgery is closed. The normative purpose of these after-hours calls is to request such a home visit (Drew forthcoming).

This data corpus cannot be treated as representative (as Drew forthcoming points out), either in terms of the kinds of after-hours calls made generally or in terms of the manner in which doctors manage such calls. Moreover, it is likely that definitions of “the family” vary—for the participants in these calls and for people generally—across their occasions of use. Analysis of these calls begins to chart the deployment of family reference terms in one such specific context.

In all of these calls, the doctor is a “locum” (a stand-in for the doctor with whom the patient is registered), such that he knows neither the caller nor the patient, nor does he know anything about their family circumstances. Interactions between the patients and their usual physicians would be conducted very differently because most references to nuclear family members could be done by using recognitional forms of reference (i.e., their names). However, the range of recurrent occasions in modern societies in which recognitions cannot be used is vast, and the use of family reference terms is a potent resource in all such contexts.

The data were transcribed according to the system devised by Gail Jefferson (see Atkinson and Heritage 1984) and subsequently developed by other conversation analysts, designed to preserve those small but significant features of talk (cut-offs, silences, etc.) that interactants use in systematic and orderly ways, many of which turn out to be essential to the analyses presented here. Non-recognitional person reference forms—in particular, person reference forms drawn from the category set of the family—were very common across these calls, and I collected and analyzed them in their sequential context. I examined, in particular, *initial* person references—and the inferences associated with them—for what they show about normative understandings of the family and the interactional uses these understandings are put to.

## Reproducing the Heteronormative Family

Of the 50 calls in the corpus where the patient is not the person calling, 33 are calls on behalf of people referred to as family members (e.g., spouses, children and grandchildren, siblings, and in-laws), and 17 are on behalf of non-family members (e.g., friends, neighbors, and people for whom the callers have an institutional responsibility). Extracts 1 and 2 are examples of openings of calls on behalf of family members:

### (1) [DEC 1-2-12 BREATHLESS]

01 Doc: Hel:l̩o,  
 02 Clr: Hel:l̩o, is tha' du- doctor?  
 03 Doc: <Yes, Doctor ((deleted)) speaki:ng,  
 04 Clr: i: i: (Yeah) Couldja's call an' see my wife  
 05 please,

2. The calls were recorded by the doctor, and many of the names (of people and places) and other identifying information were deleted by him, at his discretion and before the tapes were released. This appears to have involved recording silence over identifying information. Deletions have been indicated as such; those names that were not deleted (presumably in error) have been pseudonymized.

**(2) [DEC 1-1-10 ASTHMA]**

01 Doc: Hello:,  
 02 Clr: Hello, I'm sorry tuh trouble yuh, <my daughter has  
 03 Ventolin:e:hm one spoonful at night,<.hh I gave  
 04 her some about an hour ago< I kept (it late) with it  
 05 being so hot but sh[e st]ill can't brea:the very=  
 06 Doc: [Yes,]  
 07 Clr: =easily,

Extracts 3 and 4 are examples of the openings of calls on behalf of people who are not family members.

**(3) [DEC 1-2-6 DISLOCATION]**

01 Doc: Hello:,  
 02 Clr: Hello:, eh. .hhh I've got a friend here (.) an' 'e  
 03 dislocated 'is shoulder

**(4) [DEC 1-2-13 SICK I]**

01 Doc: .hh Hello:,  
 01 Clr: .h Ah good evenin', um: .hh this is a relief warden  
 02 from:((deleted))  
 03 Doc: Oh yes:,  
 04 Clr: Ehm- I'm ringing you up regarding one of our  
 05 tenants here. <A Misses ((deleted))  
 // ((some talk from tape deleted here))  
 06 Clr: That's right dear.  
 07 Doc: mt Ri:ght,  
 08 Clr: .hh U:m:- the lady is a diabetic.

In each Extract 1 to 4, the caller makes an initial reference to the patient using a term which displays a relationship between the patient and the caller—either a family relationship (as in 1 and 2) or not (as in 3 and 4). The analysis presented here focuses on the inferences mobilized by these initial person references and on the difference they make to the sequential unfolding of the call. It pays particular attention to the understandings of family thereby displayed and to how these understandings are deployed.

The fact that family reference terms are used at all in these calls is a contingent finding—they need not have been used. It is not sufficient to say of the speakers in Extracts 1 and 2 that they refer to the patient as their “wife” or “daughter” because that is who the patient is. There are alternative, equally “accurate” ways of referring to these persons: “a seventy five year old woman” (Extract 1), “an asthmatic” (Extract 2), and so on. The availability of person reference forms from a number of different category sets (e.g., age, diagnosis) means that person reference in terms of the category set of family can be understood as the consequence of a speaker making a selection from amongst a range of possible alternatives: so in Extract 4 the same person is variously referred to as “one of our tenants” (lines 4–5), “A Misses ((deleted))” (line 5), and “the lady” (line 8). In Extract 5—which I will later analyze in its broader conversational context—there are also two different person references to the same patient. This extract is notable in that it is the only instance in the dataset in which a family reference term is used after some other form of person reference not indexing family. The patient is referred to initially as “a patient of Doctor ((deleted))” (line 5) and only then—albeit immediately afterwards—as “my husband” (line 6):

**(5) [DEC 2-1-15 FOOD POISONING]**

01 Doc: .hhh Hello:,  
 02 Clr: .hh Hello:, um: I'm: ph- (.) phoning up fer:  
 03 Doctor ((deleted))  
 04 Doc: Yes.

05 Clr: I have a:b- a: patient of:h:: Doctor ((deleted))  
 06 my husband here,

This initial person reference locates the patient in relation to the doctor rather than, as in all other instances, in relation to the caller. Note that this form of person reference, in principle, could have been used in any and all of the other calls in the corpus—in many of which the doctor subsequently asks for just this information (e.g., see Extracts 20 and 21).

Across these calls, then, family reference terms displaying the relationship between caller and patient are systematically selected as initial person references, where there are equally accurate alternatives drawn from non-relational category sets (diagnostic category, age, sex, occupation, etc.), as well as an alternative type of person reference designed to display the relationship between the doctor and the patient.

In the following sections I explore how the deployment of these initial person references relies on and constructs a normative understanding of family: as related by law and by blood; as co-resident; and as an intimate, caring (gendered) social unit. In an intersection between the family and the institution of medicine as it is organized in England, members of a family are also understood to share the same family doctor.

### *Code of Law and Bond of Blood*

The definition of family employed here is indigenous to the interaction in the sense that person references like “daughter” and “son” are used by the participants and are treated by the interactants themselves—and not just by the analyst—as indexing family relationships. This is most blatantly the case when the term “family” is used as a collective term for the caller, the patient, and any other actual or potential members. So, for example, in Extract 6 the caller refers to her “daughter” (line 1), on the basis of which—and without any intervening talk to warrant it—the doctor later generates a “family” (line 63):

#### **(6) [DEC 1-1-1 DIARRHEA]**

01 Clr: My daughter's: uh Melanie she's age four:,  
 // ((61 lines of diagnostic questioning omitted))  
 63 Doc: Anyone else:: in the family with: (.) tummy bug  
 64 or anything?

Likewise, in Extract 7 the caller refers to her “son” (line 5), on the basis of which the doctor later asks about “family” composition (line 75):

#### **(7) [DEC 1-1-11 MEASLES]**

01 Doc: Hello:,  
 02 Clr: Hello, can I speak to the doctor on call please,  
 03 Doc: Yes, Doctor ((deleted)) speaking,  
 04 Clr: Hello, ehm (0.5) I was wonderin', I think my  
 05 son's got measles, an':  
 // ((69 lines of diagnostic questioning omitted))  
 75 Doc: [.hh Fine,<Any other children in your family?

By contrast, there are other kinds of relationships which are *not* treated as familial. In Extract 8 the caller refers to the patient as her “boyfriend”—a term that, in contrast with “husband” does not imply a marital relationship. In the course of this call the doctor begins to ask (at line 3) whether “anybody else in the fa-[mily]” has the same symptoms as the patient, but cuts off the word “family” after the first syllable and replaces it with “house”. (The warrant for hearing “fa-” as the first syllable of “family” comes from empirical conversation analytic research on the technology of repair: this is an instance of [pre-framed] replacement repair; Schegloff, Jefferson, and Sacks 1977:370).

#### **(8) [DEC 2-1-16 STOMACH]**

01 Clr: Um my boyfriend's uhm: really ill at the moment.

02 <'E's got really bad stomach pains. An' fever.  
 03 Em::symptoms.  
 04 Doc: R:ight?  
 05 Clr: Can anyone: come out tuh<sub>n</sub>ight to look at im?=  
 06 Doc: =(sniff) Welb- uh:m: u->sorry< who's 'is doctor?  
 07 (0.4)  
 08 Clr: 'is doctor's ((deleted))  
 09 Doc: R:ight. .hh Wull what's actually been happening  
 10 with'im  
 // ((32 lines of diagnostic questioning omitted))  
 43 Doc: Anybody else in the fa- the house got a fu- o:-  
 44 [got] hmm  
 45 Clr: [No,]

In abandoning “family” as the reference term for this unmarried couple, the doctor displays that marriage is integral to his definition of “family.” In selecting “house” as an alternative, he displays that his intention in initially selecting “family” was to ask about the health status of other people with whom the patient is co-resident, thereby also displaying an understanding of “family” members as co-resident (see next section). In this call, as in virtually all others in this corpus, it seems from the caller's description of the patient's symptoms that caller and patient are co-present; this is reinforced by the caller's selection of “come” (in her request on line 5), rather than, for example, “go.” In virtually all the calls in which the names of female callers have not been deleted from the audiotape, the title “Mrs.” is used: callers thereby display themselves as married and this may contribute to their relationship with the patient being treated as “familial,” in ways that the caller's in Extract 8 is not.

Marriage—code of law—is one key way in which, according to David M. Schneider (1968), Euro-Americans define kin; biological relatedness—bond of blood—is the other. In Extract 9 below (an extension of Extract 7), the doctor displays an implicit understanding (at lines 79 and 81–82) that children in a “family” are all the biological offspring of the same mother.

**(9) [DEC 1-1-11 MEASLES]**

01 Doc: Hello:,  
 02 Clr: Hello, can I speak to the doctor on call please,  
 03 Doc: Yes, Doctor ((deleted)) speaking,  
 04 Clr: Hello, ehm (0.5) I was wonderin', I think my  
 05 son's got measles,an': (what I should give it to  
 06 'im) or anythin',  
 07 Doc: Sor[ry?  
 08 Clr: [(and that) whether I should give 'im anything  
 09 for measles,  
 10 Doc: .hhh Oh right, ew: how old is your son?  
 11 Clr: Ah he was one last week, .hh[h  
 12 Doc: [B:right, an' an'  
 13 what's actually been happening to 'im=  
 // ((61 lines of diagnostic questioning omitted))  
 75 Doc: [.hh Fine,<Any other children in your family?  
 76 Clr: Yeah, I've got another boy,  
 77 Doc: Ha- older or younger?  
 78 Clr: Ah- [older,  
 79 Doc: [Well, must be older, mustn't he?  
 80 Clr: Olde[r, yeah]  
 81 Doc: [.hhhh ] ehhehm! Well, unless you're very  
 82 quick, sorry .hh  
 83 ah:m yeah has he had measles?

The inference that the caller's sons are both biologically hers—that she bore and gave birth to them—is displayed through the doctor's assertion (made without waiting for the caller to

answer his question) that the other boy “must be” older (line 79). It makes sense only as indexing his recollection that the patient is 12 months old and his knowledge that pregnancy lasts 9 months. This analysis of “must be” is reinforced by the doctor’s subsequent acknowledgement, at lines 81–82, that a younger child would be *possible* if the caller had been “quick.” The laughter (at line 81) and the apology (at line 82) are oriented to the sexual implications of a “quick” second conception.

Circumstances other than a “quick” second conception under which a woman could have two sons in her family with less than a year’s difference in age include (in addition to twins): the adoption of one or both children; the caller and her partner both bringing infants from prior relationships into their “blended” family; and the caller being in a lesbian relationship in which both partners had conceived and given birth within a few months of each other. These alternatives do not involve a biogenetic link between mother and son, and are not oriented to as possibilities by the doctor. His assertion that the second son “must be” older is based on, and thereby reproduces (without any orientation to so doing), the concept of the mother/son relationship as normatively biological.

People who are not biologically related to their child (adoptive parents, step-parents, lesbian/gay co-parents) construct (sometimes precarious) claims to parenthood in the context of this assumption (e.g., the lesbian mother quoted in Hayden 1995 who describes feeling like a fraud “if I act like he’s my baby. I’m afraid someone will ask me about labor [. . .] I have to keep telling myself he *is* my baby” [p. 49]). The dependence of kinship on biology is also manifested when the families of origin of non-biological parents refuse kinship roles with a child (e.g., the mother of a lesbian who referred to the child she was asked to treat as her “granddaughter” as “my daughter’s friend’s daughter”; Epstein 1994:83).

### ***The Nuclear Family as Co-residential Unit***

When the doctor offers a home visit, he routinely asks the caller for a home address, and sometimes also for a home telephone number. In designing his request, he displays certain inferences about the residential arrangements between caller and patient. With only two exceptions in the dataset (a working mother calling about a child at home with his father [DEC 2-1-2] and an adult sister calling about a suicidal brother [DEC 2-1-13]), callers and the patients about whom they are calling generally seem to be co-present, as displayed through:

- (a) the formulation of the description of current symptoms (e.g., a knock to a pregnant sister’s stomach that happened “bout five minutes ago” [DEC 2-1-3], a wife who has “just fainted” [DEC 1-1-13]);
- (b) audible patients off-line (e.g., a crying child [DEC 1-2-14], an adult sister who answers a question about symptoms relayed to her from the doctor by the caller [DEC 1-1-14]);
- (c) explicit statements of co-presence; these are made only by distant relatives and non-relatives and function as accounts for the presence of the patient in their homes (e.g., “I have my brother in law staying with me” [DEC 2-1-18], “I’ve got an old friend stayin’ with me down on- from Scotland on holiday” [DEC 1-1-4]). As the analysis below displays, parents of young children, and husbands and wives, treat their co-presence as a taken-for-granted, tacit assumption and instead treat not being co-present as accountable (see [DEC 2-1-2]);
- (d) the formulation of the request to the doctor to visit the patient using the term “come” (e.g., “Can anyone come out tonight to look at him?” [DEC 2-1-16] in Extract 8, which invites the inference that caller and patient are co-present [whereas “Can anyone go out tonight to look at him?” would invite the inference that they were not]).

The inference that the patient and the caller are co-present applies across the dataset to both “family” and “non-family” callers. However, when callers are identified as spouses or parents,

the doctor makes an assumption of co-residence, whereas when they are otherwise identified, he does not. So, for example, in Extract 10 the caller asks the doctor to “call an’ see my wife please” (line 4) and the doctor asks “where do you live” (line 10)—as opposed to “where does she live”—thus displaying an inference that the caller lives with his wife, such that to call and see one is to call and see the other, with the pro-term “you” being understood as plural.

**(10) [DEC 1-2-12 BREATHLESS]**

01 Doc: Hel:lo:,  
 02 Clr: Hel:lo, is tha’ do- doctor?  
 03 Doc: <Yes, Doctor ((deleted)) speaki:ng,  
 04 Clr: i:i:Couldja’s call an’ see my wife please, .h[h  
 05 Doc: [Yes:.  
 06 Clr: She’s breathless.<She can’t .hh get ‘er  
 07 breath.hh! .h[hhh ]  
 08 Doc: [What]’s: her name?  
 09 Clr: ((deleted))  
 10 Doc: Ru-an’ where do you live.

In Extract 11, the caller announces that his “wife” has fainted and, after some diagnostic questioning, the doctor asks “What’s your address” (line 40) in order that he might “pop round and see her” (lines 40–41), thereby again displaying the inference that the caller’s address is also the wife’s address.<sup>3</sup>

**(11) [DEC 1-1-13 FAINTED]**

01 Clr: =Eh: my wife has uh: just fai:nted, .hh She:’s  
 02 (0.7) been to:: the doctor’s a:nd eh: our doctor  
 03 at ((deleted)) gave ‘er: .hh some painkillers  
 04 because ‘e said she had a: um a virus in the bowel,  
 05 (0.2)  
 06 Doc: R:right,  
 07 Clr: Eh: she’s been in be:d, and she had a sort’ve  
 08 fainting spell  
 // ((18 lines omitted – describing lead up to  
 fainting))  
 26 Clr: ... she just slumped and banged her head on the bed  
 27 and fell on the floo:r,  
 28 Doc: Mm hm,  
 29 Clr: So she’s lyin’ there now till she recovers,  
 // ((11 lines of diagnostic questioning omitted))  
 40 Doc: What’s your address, and I’ll pop ‘rou  
 41 an’ se[e’er  
 42 Clr: [(It’s) ((deleted))  
 43 Doc: .hh Oh-kay; I’ll be about twenty minutes.

The assumption of co-residence displays that it is normative, in these conversationalists’ culture, for husbands and wives to live together. As Kath Weston (1998:74) points out, the normative power of co-residence as part of the definition of a family is also evident in the fact that lesbian/gay organizations in the United States have helped to frame domestic partnership legislation that stipulates co-residence for a specified period—anything from three months to a year—before an unmarried couple can register to achieve the legal standing entitling them to benefits available to married couples (see also Kitzinger and Wilkinson 2004a).

3. Although the use of “call” in Extract 10 (line 4) may invite the inference that the parties are co-present, at least in British English a request to “call” on someone does not necessarily imply either the co-presence of the speaker and the person to be called upon, or their cohabitation—as is instantiated by this example from a telephone conversation in which Lesley (who, as is clear from other calls in the corpus, does not live with her mother-in-law) asks a plumber’s wife: “Could you:r husband call on my mother in law please” [Holt 1–6].

The assumption of co-residence is also routinely displayed when parents phone on behalf of children. Following the reference to a patient as “my daug:hter, Jean” (and subsequent talk during which the daughter is said to be two years old), the doctor asks simply “where d’you live” [DEC 1-2-9]; when the patient is “my daughter who’s uh: .hh just coming fuh nineteen months old” [DEC 2-1-7 SICK], the caller later says, “my address is.” An assumption is thereby displayed that the doctor will understand that she and her daughter share the same home address, such that the caller’s address is what is needed for the doctor to visit the patient.

By contrast, family members who are not children or spouses are not unproblematically treated as co-resident. In the calls from which Extracts 12 and 13 are taken, the callers show, through their description of the patient’s current symptoms and their own attempts to relieve them, that they currently must be at the same location. However, the doctor displays problems with treating these callers and patients as co-resident. In Extract 12, after a caller’s account of his adult daughter’s medical problems (adult, as the problems are related to the termination of a pregnancy), the doctor does not (as in Extracts 10 and 11) ask some variant of “where do you live?” or “what’s your address?” Instead, he designs his question in such a way as to display his inference that caller and patient are only temporarily (“at the moment”) in the same home, and that the address he needs is the patient’s current location, whether at the home of caller or patient. The inference that the patient might be at either of two possible locations is premised on an inference that patient and caller are not—or may not be—normally co-resident.<sup>4</sup>

**(12) [DEC 1-2-11 DAUGHTER]**

01 Clr: I’m ringing about my daughter. She’s doubled up  
 02 in pain ( ) t! stomach  
 // ((64 lines of problem description and diagnostic  
 questioning omitted))  
 67 Doc: An:’whe-whe:re are you at the moment. mhh What’s  
 68 her address.

In Extract 13, the doctor launches his question in such a way as to display an inference that the caller and her daughter do not live together, and then repairs this to display an awareness that, whatever their living arrangements more generally, mother and daughter are currently at the same location.

**(13) [DEC 1-2-7 CONTRACTIONS]**

01 Clr: I’m phonin’ for my daughter, e:hm (0.7) she’s due  
 02 ‘er baby the twenty fourth u’ this month  
 // ((56 lines of diagnostic questioning omitted))  
 59 Doc: Where does she li-where are you, What’s your  
 60 address

Likewise, callers display what they take to be normative living arrangements in first referring to the patient. No caller in the data corpus ever says that a spouse or child lives with them—that is something which, they take it, goes without saying (despite the number of divorced and separated couples now parenting from separate households; Jacobson et al. 2001). Instead, they use a family reference term and then immediately describe the patient’s symptoms (as in Extracts 10 and 11), and it is on the basis of this family reference term that the doctor then displays an inference of co-residence.

4. Here, as elsewhere in this article, space constraints preclude inclusion of the conversations in their entirety; however, in neither of these extracts could anything in the omitted material reasonably underwrite the doctor’s reluctance to ascribe co-residence to these callers and patients. In fact, the situation is rather the reverse in Extract 12 where between lines 2 and 67 the caller reports on a range of different remedies attempted with a daughter who “had a operation to terminate a pregnancy on Tuesday”—three or four days before the call—none of which has been successful in alleviating her pain. This invites an understanding that caller and patient have been co-present at least sometimes over the course of the last three or four days, and hence might make possible the inference of co-residence, here withheld.

Through the normative treatment of some person reference terms as implicative of co-residence, and others as not, the traditional nuclear family of co-resident parents and children is reproduced. The non-normativity of all alternative arrangements is constituted in part by precisely the normative assumptions displayed here. In these calls, the interactants draw on what they take to be normative about kinship and living arrangements in their culture, and use it as a resource in negotiating medical care. Without being oriented to doing any such thing, they are reflecting and reproducing their normative culture.

### *Intimate Caring, Gender, and Family Designations*

The doctor in these calls routinely displays an assumption that any adult calling for a child, thereby demonstrably engaged in an act of caring on her or his behalf, is that child's parent. So, for example, the "little girl" of Extract 14 is subsequently referred to by the doctor as the caller's "daughter" and "the baby" of Extract 15 as "your first," although in neither case do these callers specify that the children about whom they are calling are their own.

#### **(14) [DEC 1-2-3 ULCERS]**

01 Clr: I've got a little gi:rl of nineteen months.  
 02 Doc: R:ight,  
 03 Clr: An' I've just noticed in 'er mouth. that she's  
 04 got .hhhh at least three: quite bad ulcers on 'er  
 05 tongue.  
 // ((13 lines describing symptoms omitted))  
 19 Doc: Ri:ght, sorry. .hh So- so how old didju' say-  
 20 you say your daughter was,

#### **(15) [DEC 1-1-5 COLIC]**

01 Clr: It's thee: (0.4) the baby, she's: (0.4) just  
 02 comin' up on four weeks old,  
 03 Doc: Right,  
 // ((107 lines of diagnostic questioning omitted))  
 111 Doc: [h Is she] the second baby? or (.) your first, yeah

Thus, when callers say they "have" children or babies, this is treated as claiming a kinship relationship. By contrast, the caller who says "I have a gentleman that's in a very bad way" [DEC 1-2-17] is not treated as claiming a kinship relationship. The assumption that an adult calling on behalf of a child is (unless otherwise specified) the parent of that child reflects, and reproduces, cultural understandings that parents (especially mothers) are responsible for the care of their children.

The analysis of Extracts 14 and 15 goes some way towards offering empirical support for Sacks's (1972b; 1995a) famous claim that when we hear "The baby cried. The mommy picked it up," what we hear is that the "mommy" who picks the "baby" up is the mommy of that baby. Apparently the doctor hears, and is intended to hear, "I've got a little gi:rl" and "it's the baby" as indexing familial relations between speaker and child. However, whereas Sacks simply claims that "baby" is a family reference term, the data presented here show that the terms "baby" and "girl" are, in the context of these calls, treated and understood by these social participants themselves as family reference terms, even though (unlike "daughter") they are not specific to familial relationships and can be used in other contexts to refer to non-kin.

The social norm that parents care for their sick children is apparent in this dataset in that, in fact, it is indeed overwhelmingly a parent, and more specifically a mother, who performs the action of calling the doctor on behalf of a sick child. More importantly from the conversation analytic perspective on normativity advanced here, the activity of calling the doctor is understood by social participants with reference to the social norm that makes caring for children a category-bound activity, such that those who make such calls on behalf of their

children overwhelmingly select person reference terms that display the parent/child relationship (e.g., “son,” “daughter,” etc., as in Extracts 2, 6, 7, and 9). Moreover, as we have seen, those who do not select such person references nonetheless have their more ambiguous—and not, strictly speaking, familial—terminology (“baby,” “girl,” “boy”) treated with reference to this social norm, and are identified as mothers on the basis of the category-bound activity they are performing (caring for children, as in Extracts 14 and 15). These data also, thereby, provide evidence for Sacks’s (1995a) claim that “for an observer of a category bound activity, the category to which the activity is bound has a special relevance for formulating an identification of its doer” (p. 259). In sum, the family is produced as a locus of caring not simply because it is, in fact, overwhelmingly parents who do call the doctor on behalf of their children, but also because those who care for children produce themselves, through their selection of familial terminology, as the parents of their children, and not as members of whatever other category sets they can also claim to be members of.

The inference that people calling on behalf of children are their parents can be so strong as to override even clear statements to the contrary, as in Extract 16 in which the caller identifies the patient as a baby who is not her own (lines 1–2). This statement is ostensibly not heard, or not understood, by the doctor. He subsequently queries her identity (line 21), such that she finds herself explaining (in lines 24–25) why it is she, and not the mother, who is calling.

**(16) [DEC 1-2-16 BABY I]**

01 Clr: I’ve got u:m .h my next door neighbor’s baby’s  
 02 not very well.<She keeps losin’ ‘er breath an’ .hh  
 03 um (.) bringin’ up sick and everything an’ she  
 04 keeps cryin’. <She’s been cryin’ for about four  
 05 hours,.hhh They don’t know what’s wrong with ‘er.  
 // ((15 lines of diagnostic questioning omitted))  
 21 Doc: Are you the mother.  
 22 Clr: No, I’m the next door neighbor.h .h  
 23 Doc: Right.  
 24 Clr: The mother’s lookin’ after the baby at the  
 25 moment. hh .hh  
 26 Doc: An’ she’s- I see. Okay doke.

In this dataset, no parent provides an account for why he or she, as opposed to another, is making the call.

Evidence that, as feminists claim, women’s caring role is not just statistically more common, but also socially normative is also displayed in these calls. First, more women call on behalf of others than do men (only 11 of the 50 such calls are from men). Second, the trend in the data is that if a male calls on behalf of a patient (of either sex), he is more likely to be offered a home visit than is a female caller.<sup>5</sup> One reason for this may be the doctor’s expectation—displayed to female callers, and never to males—that women will be free to bring the patient to see him the following day: as in Extracts 17 (a mother calling about her child) and 18 (a wife calling about her husband):

**(17) [DEC 1-1-9 CONJUNCTIVITIS]**

01 Doc: An’ if you’re worried in the morning, bring ‘im  
 02 along to the morning surgery,

**(18) [DEC 2-1-15 FOOD POISONING]**

01 Doc: If you wanted to bring ‘im along in the morning  
 02 I’ll have a loo[k at ‘im.]

5. The sample of male callers is small, and this finding does not quite reach significance at the  $p < 0.05$  level ( $\chi^2 = 3.57$ ,  $df = 1$ ,  $p < 0.10$ , critical value 3.84).

Family carers are often (though, according to Gubrium and Holstein 1990:95–112, not always) expected to have intimate personal knowledge about the patient’s personal circumstances, previous medical history, and current medical needs. In history-taking from callers identified as “mothers” and “wives,” the doctor displays through question design his expectation that callers will be able to provide him with personal medical information. Of wives he asks: “what treatment did he put your husband on?” [DEC 2-1-4]; “Has he had any problems in the past, with ‘is stomach,” [DEC 2-2-2]; and “Has he ever had anything like this befo:re?” [DEC 2-2-4]; and of a mother: “has she had any illnesses in the past of any note?” [DEC 1-1-1]. Husbands are asked: “She ever had those [codeine phosphate tablets] befo:re,” [DEC 1-1-13]; and “Does she have a problem with ‘er chest normally,” [DEC 1-2-12]. The doctor displays on only one occasion an orientation to the possibility of a spouse not having the information requested: he asks a husband, “When was her last period. D’ you know?” [DEC 1-2-15].

By contrast, non-familial callers are not expected to have intimate knowledge of the patient. When a caller identifies herself as an institutional representative (Warden Services), the doctor asks, “does she have any past history *that you know about*” [DEC 2-1-5, my emphasis], thereby displaying an expectation that she may not know.

Non-familial callers are unapologetic about their lack of knowledge of the patient’s medical needs:

**(19) [DEC 1-2-17 BREATHING]**

01 Doc: All he needs is a bit of a Nebulizer, .hh [Diyih]  
 02 Clr: [( )]  
 03 Doc: Diyiknow how to use that?  
 04 (0.4)  
 05 Clr: No but he knows how to use it, doesn’t he!  
 // ((18 lines omitted, in which doctor advises on  
 drugs))  
 24 Doc: Is ‘e also: got some steroids with ‘‘im.  
 25 Clr: Oh I don’t know a damn! I don’t know what ‘e’s got,  
 26 Doctor

No such blithe confessions of ignorance are ever produced by husbands and wives, or by parents of children. Instead, close family members treat themselves (and are treated by the doctor) as accountable for not having this kind of information: “I don’t know what it was earlier on - I wasn’t here you know,” says Melanie’s mother [DEC 1-1-1], who has already explained that she was at work when her daughter’s illness started; “It’s hard trying to remember everything” says a wife [DEC 2-1-4]. Callers treat themselves as accountable for having intimate knowledge about their children, husbands, and wives (as the caller in Extract 19 does not), thereby re-inscribing the taken-for-granted inference that “close” kin—which they are thereby displayed to be—normatively have this kind of knowledge about each other.

In sum, unless otherwise accounted for (e.g., by the institutional relationship displayed in the caller’s self-identification as a “relief warden” in Extract 6 above), making a call to a doctor on behalf of another implies that the caller is in an intimate caring relationship with the patient. The deployment of family reference terms to refer to the patient, and the inferences which demonstrably attach to these, both display and reconstitute the family as the culturally privileged site of intimate caring it is already understood to be.

### *The Family Doctor*

The analysis in this section shows how co-interactants display the inference that in the culture of which they are co-members all family members (parents and children alike) share the same family doctor. This arrangement is, of course, culturally specific and may differentiate U.K. from U.S. (and other) medical cultures. However, the general argument advanced here is generalizable to every culture—that cultural norms (including those associated with

heteronormativity) are displayed in talk, and that analysts can read from participants' talk-in-interaction whatever practices are normative in their particular culture.<sup>6</sup>

As noted, the doctor in these calls is a "locum" taking sole temporary responsibility for a multi-doctor practice, and he routinely asks for the name of the doctor with whom the patient is registered. In designing this question, he displays his inference that those calling on behalf of family members are registered with the same doctor as the patient, whereas other callers are not. For example, in Extract 20 a woman calling about her husband's swollen testicles is asked, "have you seen your own doctor at all"—a question which makes sense only if the pro-term is understood as plural, such that the woman's doctor is also her husband's:

**(20) [DEC 2-2-4 SWOLLEN TESTICLES]**

01 Doc: .hh How can I help. .hh  
 02 Cld: .hhh U::m well my husband's- he's been quite  
 03 poorly for about the last two or three da:ys,  
 04 a:nd u:m (.) he's passing wa:ter a lot an' 'is  
 05 testicles are swollen an' 'e's rea- lotta pain in  
 06 the bottom of 'is body like. (.hhhhh)  
 07 Doc: R::igh[t , ]  
 08 Cld: [(Um)] hmm hmm! ((throat clear))  
 09 Doc: (.hh) An:d: >sorry< how long's that-  
 10 Cld: .hh[h]  
 11 Doc: [b]een going on for.  
 12 Cld: Aw, two days. But it's just gettin' wo:rs, e,  
 13 Doc: Has- Have you: seen: (.) your own doctor at all?<sup>7</sup>

Similarly, in Extract 21 a mother calling about a child's sickness is asked, "who's your doctor," thereby displaying the assumption that mother and child share the same doctor:

**(21) [DEC 2-1-7 SICK III]**

01 Clr: ... my daughter who's uh:: just coming fuh nineteen  
 02 months old, um: .thh yesterday she was feelin' very  
 03 sick.  
 // ((74 lines omitted, of problem presentation,  
 diagnostic questioning, and diagnosis))  
 78 Doc: Who's your doctor,

By contrast, non-family members are assumed not to share a doctor, with the question formulated as "Who's his doctor?" [DEC 2-1-16 ] or "Who is his doctor actually" [DEC 1-2-17]. A caller on behalf of an adult son is asked, "Who- who's her doc- your: t! his doctor?" [DEC 1-2-19]. Likewise, the caller who identified herself as "only 'is grandma" (i.e., kin, but not close kin) is asked, "O:kay, an' who's your doctor normally, or his doctor." [DEC 2-1-9]: in the original formulation the doctor displays an orientation to the caller as family; in his repair, he treats her as distant kin, unlikely to share with a grandson a family doctor.

Callers—especially spouses—also make available in their talk the inference that nuclear family members have the same doctor and that others do not. A husband of a wife who has just fainted explains that "She's been to the doctor's and our doctor at ((deleted)) gave her some painkillers" [DEC 1-1-13]; a husband of a couple not registered with the practice asks,

6. The norms identified in earlier sections of this article are also culturally specific: the norm of cohabitation is not displayed in those cultures in which husband and wife live separately, either in their natal homes or in men's or women's houses (Barnard and Good 1984:78–83) or in cultures in which children do not normatively live with their parents (Ingoldsby 1995:119); the norm of "caring" between spouses is not displayed in cultures in which husband and wife are neither intimate with nor care for one another, and indeed never meet after their ritual ceremony (Gough 1968).

7. As is evident from the repair, this turn was initially designed to be "Has he seen his own doctor" and was specifically altered to display an inference that the woman would share the same doctor as her husband, and would have accompanied him to the surgery.

“Did you want to know where our doctor was?” [DEC 1-1-6]; and a wife of a husband with possible food poisoning reports unproblematically the advice of a previous doctor to “contact our own doctor” [DEC 2-1-15]. What is interesting about this latter case is that it turns out that husband and wife do not, in fact, have the same doctor. The exchange in which this statement is made is reproduced in Extract 22 (an extension of Extract 5), described earlier as unique in the corpus for the deployment of a non-familial person reference (line 5)—typical of institutional calls—followed by a familial person reference (line 6):

**(22) [DEC 2-1-15 FOOD POISONING]**

01 Doc: .hhh Hello:,  
 02 Clr: .hh Hello:, um: I'm: ph- (.) phoning up fer:  
 03 Doctor ((deleted))  
 04 Doc: Yes.  
 05 Clr: I have a:b- a: patient of:h:: Doctor ((deleted))  
 06 my husband here,  
 07 Doc: Mm hm̩  
 08 Clr: Ahm: we've just come back from:: holiday, from  
 09 Wales We'[ve h]ad to call the doctor out  
 10 Doc: [Mm hm] .mhh[ h h t. h h h ] =  
 11 Clr: [this morning in Wales,] =  
 12 Doc: = [egh-khmm! ((sneeze))]  
 13 Clr: = [ for my husband ]  
 14 Doc: Yeah,  
 15 Clr: Um:: I think it could be: food poisonin'.='E's  
 16 been given: ((swallow)) t! tablets: .hh ta take,  
 17 to stop the diarrhea, .h[h]  
 18 Doc: [Y]es,  
 19 Clr: Um:: hh (0.5) but um:: .hh it hasn't actually  
 20 stopped it 'n h- he's still sort'uv li:ke losing a  
 21 lot of li:quid. .hh Still very very feverish.  
 // ((11 lines of diagnostic questioning omitted))  
 33 Doc: .hhh An::d uh what- you saw the doctor this  
 34 morning?  
 35 Clr: Yes. [But] the doctor advised us if it got any=  
 36 Doc: [Hm:]  
 37 Clr: = worse to contact [our ] own doctor.  
 38 Doc: [Hm ]  
 // ((65 lines of diagnostic questioning and diagnosis  
 omitted))  
 103 Doc: If you wanted to bring 'im along in the morning  
 104 I'll have a loo[k at 'im.]  
 105 Clr: [Well, we ] actually live the other  
 106 side of ((deleted)) (.hhh) but- we've: u:m we live  
 107 at now. So it's quite a struggle tuh get 'im all  
 108 the way up tuh ((deleted))  
 109 Doc: I see.<Well so, have you changed your: doctor.  
 110 Clr: M- u- u:hm: no, 'e hasn't changed 'is doctor  
 111 because he likes- 'e used to live up by there.=  
 112 Doc: =Yeah,  
 113 Clr: t.hh An::d because 'e likes bok- Doctor  
 114 ((deleted)) 'e ne- 'e decided not tuh change it.  
 115 eh-hh!  
 116 Doc: Right. >Yeah.<=

Over the course of this call, a hypothetical family doctor is first conjured into being and then dissolved. This person is first invoked by the caller in seeking to justify the need for a home visit: she reports having been advised by a holiday doctor to contact “our” own doctor

(line 37). Later, in response to the caller's account of the difficulties of visiting a surgery some distance from home, the doctor invokes this same person: "Well, so have you changed your: doctor" (line 109, with "you" and "your" here treated as plural). The hypothetical family doctor finally dissolves in lines 110–14 where "his doctor" makes an appearance instead—and it becomes apparent that husband and wife have different doctors, with this accounted for in terms of "his" previous residence, "his" preferences, and "his" decisions. The way in which a normative inference (here, that spouses share a doctor) acts to shape the interaction is powerfully apparent in this call.

In sum, I have shown that the heteronormative definition of the family reflected and constructed by these social participants in the course of their everyday lives comprises wife and husband, co-resident with their biologically related, dependent children, with the wife/mother taking primary responsibility for caring for sick family members and for contacting the (shared) family doctor. The normative construction of the family is invoked, deployed, negotiated—and occasionally resisted—by social participants for whom the business at hand is caring for a sick person and trying to secure a home visit from a doctor. However, in conducting the business of their everyday lives, without conscious design or oppressive intent, they reproduce their society's heteronormative social order.

## Conclusion

In this analysis, I have sought to excavate what Euro-American readers—as cultural members—already "know" and take for granted: that families normatively live together and care for one another. I have analyzed the mundane understandings of family embedded in these calls to show what these understandings are, and how they are displayed by people who are not simply describing, but are actively deploying family reference terms for interactional purposes. In conclusion, I will: (a) examine some of the interactional uses to which these family reference terms are put; and (b) extrapolate from these findings the implications of this quotidian reproduction of heteronormativity for the problem of heterosexism more broadly.

### *Interactional Uses of Family Reference Terms*

The use of heteronormative terms and inferences in these calls is not designed to display anti-gay prejudice or to discriminate against non-heterosexual people. Rather, speakers are deploying person reference terms that they treat as ordinary and natural in pursuit of the interactional goals related to their medical concerns. A key interactional use of reference terms relating to the traditional nuclear family is to render ordinary and natural the action being performed by callers in contacting the doctor on behalf of these particular patients. Calling the doctor is—along with other actions described in the calls (such as sponging down a feverish child, helping a spouse to the toilet, preparing special foods or drinks)—demonstrably an act of caring. Caring activities are, as has been shown in the preceding analysis, category-bound to the particular categories of people who constitute the nuclear family, especially the wife/mother. This means that callers who contact the doctor and report, "My husband isn't very well," or, "I think my son's got measles," constitute themselves as ordinary people doing an ordinary and natural thing in calling on behalf of these patients in particular—because these patients, referred to by terms which display them as members of the caller's nuclear family, are precisely the people for whom "caring" is an ordinary and natural activity. As demonstrated above, a wife/mother is culturally understood to be bound to her "husband" by marriage and to her "son" by blood, to live with them, to care for them, to have intimate knowledge of their medical needs, and to share with them a family doctor. Calling on their behalf is rendered thereby a wholly non-accountable activity: nothing special is happening in terms of the relationships displayed. Whatever other interactional hurdles the caller has to

negotiate (conveying the nature of the medical problem, describing the symptoms as sufficiently severe to merit a home visit, and so on; Drew forthcoming) she does not have to deal with the issue of why she rather than some other person is calling on behalf of the patient. The fact that she is the one calling is rendered ordinary and natural.

Here, nuclear family reference terms are being used, as Donna J. Haraway (1997:53) has theorized, as a technology for producing the effect of “natural” relationships. The use of these reference terms mobilizes the inferences which attach to such relationships, obviating the need for the caller to account for her caring activities and facilitating a smooth and unproblematic doctor/caller interaction. The sheer ordinariness of a parent calling on behalf of a child, or one spouse on behalf of another, makes the use of these terms a powerful resource for “doing being ordinary” (Sacks 1984), with all the interactional benefits (of not having to provide accounts, explanations, justifications, etc.) that attach to being an “ordinary” person doing a “natural” activity.

Nuclear family terms also are used to co-implicate a third party in the decision to call the doctor. Callers frequently display an orientation to their call as constituting a demand on the doctor’s time and energy (e.g., via expressions of regret for the necessity of making the call or requesting a home visit: “I’m afraid I’m- I’m sorry, but I’ve gon’ t’av to call ya out” [DEC 1-2-15]). They reduce their own culpability in this respect by allocating some of the responsibility for the call to other family members—in this dataset, always spouses—who have either allegedly requested that the call be made, or whose purported anxieties for the patient have prompted the call. For example, when one caller’s suggestion that her daughter may have mumps meets with some skepticism from the doctor, she says, “My husband just said ta phone ya” [DEC 1-2-8]. Another caller, having described how his pregnant daughter is vomiting and has a slight discharge, co-implicates his “wife” in the anxieties this is causing: “It won’t stop at the moment, e- which is obviously: (.) worrying me, an:d my wife” [DEC 1-1-7]. Patients who call on their own behalves also occasionally claim that they are doing so in response to the promptings of a spouse, thereby displaying what John Heritage and Jeffrey Robinson (forthcoming), drawing on Jefferson (1984:351), call “troubles resistance”—that is, that they are not calling the doctor lightly and have tried to deal with the problem themselves. The marital unit terminology of “husband” and “wife” offers a resource for co-implicating other people whose involvement with caller and patient is treated as self-evident.

### *Implications for the Problem of Heterosexism*

The mundane, everyday use of family reference terms in these calls constitutes a major resource for ordinary folk who are not oriented in any way to LGBT concerns but who are simply getting on with the business of their lives. In so doing, the social order they reproduce is profoundly heteronormative: in these calls the nuclear family is always a heterosexual one, individuals are (apparently) universally heterosexual; sexual orientation—of any kind—is simply not an issue. It is precisely this untroubled reproduction of a heteronormative world that—from an analyst’s point of view—contributes to the problem of heterosexism.

These casual displays of heterosexuality in the service of local interactional goals constitute a mundane instance of heterosexual privilege by those who take for granted, as others cannot, their access to their culture’s family reference terms. Such terms are not available—in any unproblematic way—to lesbian or gay couples in England, where (as in most other countries) same-sex marriage is not permitted under law (see Kitzinger and Wilkinson 2004a). A study in which gay men were asked about their lexical choices in referring to their “lover”/“partner”/“friend”/“boyfriend” points to a plethora of self-consciously articulated difficulties and concerns (Harvey 1997; see also Land and Kitzinger 2005 for an analysis of lesbians attempting to deploy the terminology of “wife” and referring to a female “partner” in the course of everyday activities). The normative understanding is that a family unit properly comprises one (and only one) mother and father—what Sacks (1972b) refers to as the

“proper number of incumbents for certain categories of any unit . . . a nation-state may have but one president, a family but one father, a baseball team but one shortstop on the field, etc.” (p. 221).

Family researchers have emphasized the range and diversity of “emergent and reconfigured forms of family life” (Lempert and DeVault 2000) in contemporary modern societies. According to the 1991 Census, only 14.6 percent of UK households contained one adult male and one adult female, with between 1 and 3 dependent children, where only one of the adults was in employment (Bernardes 1999). The acknowledged existence of family diversity does not, however, necessarily map onto social members’ displayed understandings of the family as a normative concept. It is not necessarily the case that the families of which these callers are members are as rigidly traditional as their displayed understanding of “the family” implies: they include several mothers who work outside the home, fathers/husbands who call on behalf of sick family members, an unmarried couple, a family dealing with a daughter’s abortion, the couple who do not share a normative “family doctor”—and presumably other kinds of non-conformity which were not revealed in these calls. If these callers had been interviewed on the topic, they may well have produced more nuanced and complicated accounts of family life; however, what I have shown in their daily interactions, when family terminology is a resource not a topic, is their deployment of the traditional normative construction of “the family” as a distinct, co-residential, heterosexual marital unit. This common-sense understanding is produced by callers and doctor in interaction and is oriented to as normative even when it is breached, as when accounts are offered for the presence of others (such as friends) in the home (Extract 3) or when non-normative medical arrangements are glossed as normative (Extract 23).

The interactional trouble that arises in these calls when normative understandings are breached enables us to extrapolate the problems that might confront a lesbian or a gay man contacting a doctor on behalf of partner or child (especially any child of whom she or he is neither a biological nor a legally appointed adoptive parent). Such a caller lacks as a resource the culture’s family reference terms, and the inferences associated with such a resource, used so smoothly by most of these (apparently) heterosexual callers. Research (based on self-reported data) on lesbians’ and gay men’s experience of the physician-patient relationship has found that 17 percent report having avoided or delayed seeking health care for reasons to do with their sexual orientation (Stein and Bonuck 2001) while 27 percent report negative or problematic experiences with their children’s health care related to sexual orientation or family constellation (Mikhailovich, Martin, and Lawton 2001; see also Riordan 2004, for the experience of lesbian and gay physicians). Although some of these negative interactions are the product of explicitly homophobic behavior including intimidation and humiliation from health care professionals (e.g., Stevens 1992), many must derive from the underlying assumptions of universal heterosexuality incorporated into the culture’s family reference terms and the mundane heterosexism (Peel 2001) to which that gives rise. Research on lesbian and gay families more generally (e.g., Stacey 1998; Weston 1991), like the medical research cited above, has used self-report data to highlight the heteronormative context for same-sex couples and their children. The analysis presented here contributes to that literature a detailed analysis of how heteronormativity is grounded in the empirical details of talk-in-interaction (see also Kitzinger 2000, 2005; Land and Kitzinger 2005).

In conclusion, analysis of these family reference terms, the inferences normatively associated with them, and the interactional uses to which they may be put in the context of after-hours medical calls have shown that (and how) tacit, taken-for-granted concepts of “the family” are reflected in, and reproduced by, the talk of social participants. Through their deployment of family reference terms in conducting the business of their ordinary lives, the speakers in this dataset both reflect and (re)construct their society’s normative definition of family as composed of a co-residential married heterosexual couple and their biological children. This analysis has also demonstrated that heterosexism can be produced and reproduced,

even—and perhaps especially—where there is no sign of trouble in social interactions. It may be particularly important to target for analysis precisely those everyday interactions which seem unremarkable, where nothing special appears to be happening, because what is always happening on such occasions is the reproduction of the normal, taken-for-granted world, invisible because it is too familiar. Here, in the specific context of requesting a home visit from a doctor, we see heteronormativity in action. In unravelling the social fabric of ordinary, everyday life, LGBT activists and researchers can make visible and challenge the mundane ways in which people—without deliberate intent—reproduce a world that socially excludes or marginalizes non-heterosexuals.

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