Getting Down to Business
Talk, Gaze, and Body Orientation During Openings of Doctor-Patient Consultations

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This study examines the openings of British general-practice medical consultations. The authors use conversation analysis to analyze how doctors' and patients' practices of gaze and body orientation organize interaction such that doctors routinely initiate the sequence wherein patients disclose their chief complaint. Gaze and body orientation communicate levels of engagement with and disengagement from courses of action. As doctors and patients accomplish regular tasks preparatory to dealing with patients' chief complaints, doctors use gaze and body orientation to communicate that they are preparing but are not yet ready to deal with those complaints. In response, patients wait for their doctors to solicit their chief complaint. These findings have implications for research on nonverbal communication, interactional asymmetry, and power.

This study examines the first phase or the opening of British general-practice medical consultations. The primary goals are to analyze (a) doctors' and patients' practices of gaze and body orientation; (b) how doctors and patients use these practices to communicate frameworks of engagement and disengagement with courses of action and thereby with each other; and (c) the consequences of such frameworks for the organization of interaction—specifically, how doctors routinely come to initiate the sequence wherein patients disclose their chief complaint. This study has implications for research on nonverbal behavior, interactional asymmetry, and power.

Research on nonverbal communication in doctor-patient interaction has been sparse relative to that on verbal communication (for review, see Roter & Hall, 1992). The variables of gaze and body orientation have been

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examined primarily in association with variables exogenous to interaction. Far less attention has been paid to gaze and body orientation in association with variables endogenous to interaction, such as doctors' and patients' verbal behavior (Bensing, Kerssens, & van der Pasch, 1995), and the organization of doctor-patient interaction (Frankel, 1993; Heath, 1984, 1986; Psathas, 1990). Studies of the latter rely on a large body of literature that examines the functions of gaze and body orientation in ordinary conversation. Because this study also relies on this literature, a somewhat extended review is necessary.

People's body orientations communicate a frame of space wherein their long-term and dominant actions are most likely to be focused (C. Goodwin, 1981; Kendon, 1990a, 1990c; Schegloff, 1987b). This frame can be referred to as a frame of dominant orientation. The act of including people or objects within one's frame of dominant orientation by shifting the orientation of one's body communicates availability for collaborative action with the included people or objects (C. Goodwin, 1981; Kendon, 1990c). Likewise, the act of excluding people or objects communicates nonavailability. One of the most prevalent and consequential forms of collaborative action is talk. Therefore, including people within (or excluding people from) one's frame of dominant orientation communicates one's orientation to the relevance (or nonrelevance) of talking with those people (C. Goodwin, 1981).

When two or more people cooperate so that they bring the other(s) into their frame of dominant orientation, they negotiate a participation framework (C. Goodwin, 1981)—they communicate their availability to participate in collaborative action with each other. People orient to insiders and outsiders of participation frameworks, and joining or leaving participation frameworks is a process of communicative negotiation (Goffman, 1981; C. Goodwin, 1981, 1987; Kendon, 1990c; Schegloff, 1987b).

Two or more people in a participation framework do not necessarily constantly engage each other in collaborative action (C. Goodwin, 1981). There is a difference between a participation framework and an engagement framework. In the latter, people not only communicate availability for but also actual engagement in collaborative action (C. Goodwin, 1981). Gaze is an important tool with which to negotiate the development and dissolution of engagement frameworks. Gaze communicates current attention to, availability for, and participation in others' actions (Argyle & Cook, 1976; Goffman, 1967; C. Goodwin, 1981; Kendon, 1990a, 1990b, 1990c; Scheflen, 1974). Likewise, gaze identifies the intended recipients of gazers' actions (C. Goodwin, 1981; Sacks, Schegloff, & Jefferson, 1974). Thus, gazing at other people reciprocally constrains interaction by simultaneously displaying and proposing to them a state of coparticipation in collaborative action. Likewise, looking away can communicate a state of

People's understandings of gaze and body orientation are interrelated (Mehrabian, 1967). Although people's heads, torsos, and legs are often aligned toward their frame of dominant orientation, this is not always the case. The body can be viewed as an organization of segments, each of which can be oriented in different directions (Kendon, 1990a). However, even when people arrange these segments of their body to have divergent orientations, a socially understood body-segment hierarchy exists that indicates level and orientation of attention. Because the positioning of lower-body segments establishes a physical framework of limits for the positioning of upper-body segments, lower-body segments are relatively more stable and, therefore, more strongly communicate people's frames of dominant orientation (Kendon, 1990a). For example, the orientation of people's legs more strongly communicates their frame of dominant orientation relative to that of their heads and torsos; the orientation of people's torsos more strongly communicates their frame of dominant orientation relative to that of their heads.

Schegloff (1987b) argued that when people arrange their body segments so as to have divergent orientations, they communicate (a) postural instability, (b) potential postural resolutions to this instability by reference to the position of the more stable segments of the body, (c) an orientation toward multiple courses of action, and (d) a ranking of level of orientation with these multiple actions by reference to the orientation of the more stable segments of the body. For example, if people orient their heads divergently relative to their torsos and legs, they communicate (a) that the positioning of their heads is unstable relative to that of their torsos and legs; (b) that a potential postural resolution is the realignment of their heads with their torsos and legs; (c) an orientation toward at least two courses of action, one communicated by the orientation of their heads and another by that of their torsos and legs; and (d) that the course of action communicated by their torsos and legs is more long-term and dominant than that communicated by their heads.

By analyzing how doctors' and patients' practices of gaze and body orientation affect the organization of interaction, this study contributes to knowledge concerning the association between nonverbal and verbal process variables and, thus, to the establishment of a systematic theory of doctor-patient communication (see Ong, Haes, Hoos, & Lammes, 1995).

In addition to research on nonverbal communication, this study also has implications for research on interactional asymmetry (Cicourel, 1982; Emerson, 1970; Fisher, 1984, 1991; Frankel, 1984, 1990, 1995; Mishler, 1984; Roter, Hall, & Katz, 1988; Todd, 1984, 1989, 1993; Waitzkin, 1991; West, 1984). Despite the theoretical and methodological diversity of this re-
search, one commonly documented finding is that doctors' turns are predominantly first parts of sequences, in which they launch courses of action and solicit responses, whereas patients' turns are predominantly second parts of sequences, in which they provide responses (Frankel, 1990; Linell, Gustavsson, & Juvonen, 1988; Mishler, 1984; Peräkylä, 1995). The literature provides two general explanations for this asymmetry: one grounded in theory and the other grounded in interaction. Both explanations have problems.

Researchers have traditionally argued that the medical profession is socially organized such that doctors are powerful or dominant and patients are subordinate (Foucault, 1973; Freidson, 1970a, 1970b; Navarro, 1976; Parsons, 1951, 1975; Reiser, 1978; Starr, 1982; Waitzkin & Waterman, 1974). From this perspective, interactional asymmetries are conceptualized as predestined products of the imposition of and acquiescence to doctors' power (for review, see Maynard, 1991). However, research on actual medical practice has found that power is interactively achieved and that power relationships are not always in accord with theoretical predictions (Anspach, 1993; Becker, Geer, Hughes, & Strauss, 1961; Coupland, Robinson, & Coupland, 1994; Emerson, 1970; Maynard, 1991; Strong, 1979; Sudnow, 1967; ten Have, 1991). This inconsistency is due, in part, to the fact that interaction is socially organized in ways that are relatively independent of the social context as it is theoretically characterized and that interaction has its own independent effects on communication outcomes (Goffman, 1983; Schegloff, 1987a). Working from this position, recent attempts have been made to explain interactional asymmetries in terms of the organization of doctor-patient interaction itself.

One common, interactionally grounded explanation for asymmetry in institutional contexts is that doctors and patients orient to turn-taking rules that are systematically different from those that organize ordinary conversation. According to this explanation, doctor-patient interaction is understood to be akin to that in formal institutional contexts, such as courtrooms (Atkinson & Drew, 1979), classrooms (McHoul, 1978), and news interviews (Greatbatch, 1988). In those contexts, interactants not only organize the talk according to turn-taking rules that systematically preallocate turn order and turn type but are personally accountable for departures from those rules.

Research appears to reject this explanation in the context of doctor-patient interaction for at least two reasons. First, despite frequent asymmetries of turn order and turn type, doctors and patients sometimes structure interaction in ways that approximate or even simulate that of ordinary conversation, and they do so unproblematically and without sanction (Drew & Heritage, 1992; Frankel, 1989; Peräkylä, 1995; ten Have, 1991). Second, there is evidence that even during periods of interactional
asymmetry, doctors and patients organize their talk according to the local management of turn order and turn type and thus to the turn-taking rules of ordinary conversation (Peräkylä, 1995). As Drew and Heritage (1992) argued, if a complete explanation for interactional asymmetries cannot be found in a single recursive practice, such as turn taking, then it must be found in a network of nonrecursive verbal and nonverbal practices, such as the organization of participation frameworks (C. Goodwin, 1981), the design of turns (Schegloff, 1996b), the design of activities (Heritage & Sorjonen, 1994; Levinson, 1992), the organization of sequences (Schegloff, 1995), and the organization of the overall structure of talk (Schegloff & Sacks, 1973).

This study argues that doctors’ and patients’ practices of gaze and body orientation frequently explain one particular interactional asymmetry during the openings of medical consultations: doctors’ routine initiation of the sequence wherein patients disclose their chief complaint. Research has paid a significant amount of attention to how patients’ chief complaints are disclosed and for good reason. As Waitzkin (1991) noted, soliciting the chief complaint is purportedly “the greatest skill that doctors develop in taking a medical history; some commentators argue that this is the most important skill in medicine” (p. 28). Research has analyzed the questioning formats that doctors use to solicit the chief complaint, the constraints these formats place on patients’ answers, and the effects these constraints have on patients’ health care (Beckman & Frankel, 1984; Beckman, Frankel, & Darnley, 1985; Coupland, Coupland, & Robinson, 1992; Coupland et al., 1994; Frankel, 1995; Heath, 1981, 1986; ten Have, 1991). However, these studies have usually assumed that doctors initiate the sequence wherein patients disclose their chief complaint and have not examined how this asymmetry is achieved in and through interaction. This article provides such an explanation and thus addresses the construction of interactional asymmetries and how this process of construction relates to traditional notions of power.

DATA AND METHOD

The data include 86 audio- and videotaped doctor-patient consultations collected from a British general-practice health clinic in 1990. The opening phase of each consultation was transcribed for verbal behavior, gaze, and body orientation. All data were transcribed by the author and all names have been changed to maintain confidentiality (see the appendix for transcription conventions). This study uses the methodology of conversation analysis (for review, see Drew & Heritage, 1992). Due to space restrictions, only two openings are examined. Opening 1 is representative of the database and is used throughout the analysis.
Regular Components of Openings

The opening phase begins when the doctor and patient establish copresence (i.e., when the patient knocks and/or enters the office) and includes all communication behavior up to and including the successful initiation of the patient's chief complaint. After the establishment of copresence, openings contain four regular tasks: (a) greeting, (b) getting the patient to sit down, (c) securing the patient's identity, and (d) determining the patient's chief complaint (Byrne & Long, 1976; Coupland et al., 1994; Heath, 1981). The beginning of each task is indicated in the left margin of Opening 1.

Opening 1: Breathing (Verbal)

((The patient, who is female, begins in the waiting room. The doctor, who is male, begins in the consultation office. When the patient is informed by the nurse that she is next, she walks down a hall to the office.))

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<tbody>
<tr>
<td>01</td>
<td>((Patient informed that she is next))</td>
</tr>
<tr>
<td>02</td>
<td>((Knock knock &quot;knock&quot;))</td>
</tr>
<tr>
<td>03</td>
<td>&quot;C'm in:&quot;</td>
</tr>
<tr>
<td>04</td>
<td>(2.2 seconds)</td>
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<tr>
<td>T1-&gt;</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Pat:</td>
</tr>
<tr>
<td>06</td>
<td>Doc:</td>
</tr>
<tr>
<td>07</td>
<td>G'mor:ning. (3.6 seconds)</td>
</tr>
<tr>
<td>T2-&gt;</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Doc:</td>
</tr>
<tr>
<td>09</td>
<td>Have a seat. (0.5 seconds)</td>
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<tr>
<td>T3-&gt;</td>
<td></td>
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<tr>
<td>11</td>
<td>Doc: Miss:iz Rattigan.</td>
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<tr>
<td>12</td>
<td>Pat: Yes.</td>
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<tr>
<td>13</td>
<td>Doc: Right. &gt;Can I jus' put you on the machi:ne?</td>
</tr>
<tr>
<td>14</td>
<td>Pat: You ca:n.</td>
</tr>
<tr>
<td>T4-&gt;</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Doc: =hhhhjhhhhhhhhhhhhhhhhhhhhhh</td>
</tr>
<tr>
<td>20</td>
<td>Pat: [Well, (. ) me brea:thin's sho:ckin.</td>
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What follows is a detailed, task-by-task examination of the doctor's and patient's practices of gaze and body orientation contributing to the asymmetry in which the doctor initiates the sequence wherein the patient discloses her chief complaint.

**Greeting.** As the patient opens the office door, the doctor's gaze and body orientation communicate a single frame of dominant orientation.
toward a desk. The doctor is sitting at the desk with his legs, torso, and head all oriented toward the desk, his legs under the desk, and his hands over the desktop. The doctor is gazing at the patient’s medical records, thereby communicating his current engagement in the action of reading the records. Figure 1 depicts the videotape frame just as the office door begins to open. The doctor’s gaze and body orientation communicate a complete lack of engagement with the patient and complete engagement with reading the records, which is an action that is neither collaborative nor symmetrical in nature. The doctor’s gaze and body orientation communicate that he is neither a potential speaker nor recipient of talk. Therefore, at least for the moment, the identities of speaker and recipient as well as the turn-taking rules are not relevant frameworks for the organization of the interactants toward each other (see C. Goodwin, 1981).

The doctor maintains the gaze and body orientation displayed in Figure 1 throughout the summons-answer sequence at lines 2 through 3. As shown in Data Fragment 1A, after the patient begins to open the door and enter the office (a->), the doctor maintains this orientation for a lengthy 1.1 seconds (b->).
Data Fragment 1A: Breathing (Nonverbal)

As the patient enters the office, the doctor shifts his orientation. Although the doctor keeps the lower segments of his body oriented toward the desk, he shifts his gaze (i.e., current engagement) 90 degrees left to the patient from the records (b-). Figure 2 depicts the videotape frame occurring just before the greeting sequence is initiated at line 5. Although the videotape image of the patient is obscured by the opening door, it is likely that the patient is witness to the doctor’s shift in orientation; it is possible that the doctor specifically coordinates his shift with the patient’s entrance into the office.

When the doctor shifts his gaze to the patient, he communicates that (a) his head is unstable relative to his legs and torso; (b) a natural postural resolution to this instability is to return his head to a forward-facing position (i.e., toward the desk area and the records); (c) he is simultaneously engaged in at least two courses of action, one oriented toward the desk and the other toward the patient; and (d) the course of action oriented toward the desk constitutes his long-term and dominant action relative to the more transient (albeit current) action of greeting the patient (see Schegloff, 1987b). Thus, as the patient enters the office, even though the doctor moves from communicating disengagement to communicating engagement with the patient in collaborative action, his divergent body-segment orientation foreshadows the short-lived relevance of collaborative action, communicating the imminent return of his engagement to those actions included within his frame of dominant orientation.

The doctor temporarily engages the patient to greet her. The patient initiates the greeting sequence (c->). Before the patient completes her greeting, the doctor returns his gaze to the records (d->). When the doctor’s gaze reaches the records, he returns the patient’s greeting (e->), thereby closing the sequence. As foreshadowed by the doctor’s divergent body-segment orientation, the doctor has returned his head back into alignment with his lower body and his gaze to the records, again commu-
indicating full disengagement from the patient in collaborative action and full engagement in noncollaborative action. At this point, the doctor’s orientation is similar to that represented in Figure 1.

The importance of analyzing actions and activities: Patients embodied versus patients in bureaucracy. Saying simply that the doctor temporarily shifted his engagement to the patient from an ongoing state of nonengagement with the patient elides the doctor’s actions and the larger system of activity in which those actions are situated. As patients enter the office, doctors routinely disengage and then reengage actions preparatory to dealing with the chief complaint—most commonly by reading or retrieving the patients’ records. Medical records predominantly consist of descriptions of consultations and document patients’ medical problems and their management (Heath, 1982). Patients can therefore be argued to have a distributed existence within doctor-patient interaction. Patients are present or visible both in their own bodies and in entries in their records. Thus, when doctors shift their gaze to patients and then to the records, they are not simply engaging and then disengaging patients. More accurately, they are shifting their engagement from patients embodied to patients inscribed, or from patients in person to patients in bureaucracy.

Reading the records is situated within the larger activity system (Goffman, 1961; M. H. Goodwin, 1990; C. Goodwin & M. H. Goodwin, 1987; Levinson, 1992) of opening a consultation. The activity of opening interactions,
including medical consultations, routinely culminates in the first topic or the reason for the interaction (Button & Casey, 1984; Heath, 1981; Schegloff, 1968, 1986; Schegloff & Sacks, 1973). Interactants usually orient to talk that occurs before the first topic as being specifically preliminary to the first topic (Schegloff & Sacks, 1973). In doctor-patient consultations, the first topic is typically the patient’s chief complaint (Heath, 1981). Every consultation in the database used for this study contains a greeting sequence, and greetings always occur before the chief complaint. Doctors and patients demonstrate an orientation to the action of greeting as relevant within the activity system of opening a consultation and as specifically preliminary to the action of dealing with the chief complaint. Thus, by using gaze and body orientation to engage patients embodied in a predictably temporary manner, by greeting those patients, and then by disengaging from patients embodied and reengaging with patients in bureaucracy, doctors accomplish a collaborative task that is necessarily preliminary to dealing with the chief complaint while communicating that they are preparing but are not yet ready to deal with the chief complaint. Patients respond not by initiating their chief complaint, but by performing their own noncollaborative tasks preparatory to dealing with the chief complaint (e.g., closing the door), and by waiting for doctors to communicate their readiness to deal with the chief complaint.

These observations are supported by doctors’ and patients’ actions subsequent to doctors’ disengagement with patients embodied. In Data Fragment 1A, there is an extended 3.6-second silence (f->) or lapse in talk (Sacks, Schegloff, & Jefferson, 1974) immediately after the greeting sequence. During a majority of this silence, the doctor reads the records, which is an action that is specifically relevant to getting ready to deal with the chief complaint (Heath, 1982). On completion of the greeting sequence, the patient turns around (her back to the doctor) and closes the office door (g->). By responding to the doctor’s visual and bodily disengagement with her own full disengagement, the patient simultaneously displays her orientation to the doctor as communicating his lack of engagement with her embodied self, displays her orientation to the nonrelevance of collaborative action, and ratifies the doctor’s proposal of disengagement. By closing the office door, an action relevant to dealing with private medical business, the patient displays her orientation to the in-progress nature of the larger activity of opening a consultation and the eventuality of dealing with her chief complaint. Thus, the lapse at line 7 is coconstructed by doctor and patient and constitutes a continuing state of incipient talk (Schegloff & Sacks, 1973), in which both are preparing to deal with the chief complaint.

Getting patients to sit down. Both doctors and patients orient to patients sitting down as preparatory to dealing with the chief complaint (see
Doctors often verbally or nonverbally invite patients to sit. When they do, their accompanying practices of gaze and body orientation are similar to those that occur during greetings (see Data Fragment 1B).

Data Fragment 1B: Breathing (Nonverbal)

As the patient closes the door (c->), the doctor’s gaze and body orientation communicate full engagement with the records and the desk area, respectively. Just before the patient turns around after closing the office door, the doctor begins to shift his gaze to the patient from the records (a->). When the doctor’s gaze reaches the patient, he produces a palm-up hand gesture toward the chair (b->), nonverbally inviting her to sit down. When the patient turns around and the interactants achieve mutual gaze (3.2 seconds into the silence at line 7), the doctor’s gaze and hand gesture are in place. In response to the doctor’s hand gesture, the patient shifts her gaze from the doctor to the chair (c->). When the patient’s gaze reaches the chair, the doctor simultaneously verbally invites her to sit down (d->) and begins to return his gaze to the records (e->).

When doctor and patient establish mutual gaze, they establish an engagement framework that makes coparticipation relevant. The doctor initiates a form of coparticipation by nonverbally and then verbally inviting the patient to sit down. However, the doctor’s divergent body-segment orientation again communicates the temporary nature of his engagement with the patient embodied and the eventual return of his engagement to actions on or near the desk. As the doctor invites the patient to sit down, he disengages from the patient embodied and reengages with the patient in bureaucracy. This again allows him to simultaneously accomplish a collaborative task preparatory to dealing with the chief complaint and communicate his continued lack of readiness to deal with the chief complaint.
In Data Fragment 1B, the patient responds to the doctor’s disengagement (e->) by shifting her gaze from the chair to the desktop (f->). By shifting her gaze not to the doctor but to a field of bureaucratic action, the patient communicates a diminished state of engagement with the doctor embodied and an enhanced state of engagement with the doctor doing bureaucracy. The patient orients to the doctor’s shift in gaze from herself to the records as communicating his disengagement with her embodied self and engagement with her self in bureaucracy. After the patient’s gaze reaches the desktop, she responds to the doctor’s invitation with “thank you” (g->), thereby accepting his invitation and closing the sequence.

Throughout the patient’s response and the subsequent lapse in talk (h->), the patient approaches the chair in preparation for sitting down and continues to gaze at the desktop (i->). While the patient’s gaze is oriented toward the desktop, her legs and torso are oriented toward the doctor, communicating that the doctor is within her frame of dominant orientation. In this way, the patient communicates her readiness to participate with the doctor in collaborative action but does not actively solicit his engagement. The doctor and patient again coconstruct a lapse that constitutes a continuing state of incipient talk in which the patient engages in a noncollaborative action preparatory to dealing with the chief complaint (i.e., moving to sit down) and waits for the doctor to initiate a next bit of talk while the doctor engages in the noncollaborative action of preparing to deal with the chief complaint.

Securing patients’ identities. Prior to dealing with the chief complaint, doctors need to know patients’ identities for at least two reasons: They must ensure that they are treating the correct patient and that they have the appropriate records. These tasks are accomplished by confirming or searching for a patient’s identity (Heath, 1981). Doctors’ practices of gaze and body orientation occurring during the identity-confirmation/search sequence are similar to those that occur during greetings and invitations to sit down (see Data Fragment 1C).

Data Fragment 1C: Breathing (Nonverbal)

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<tr>
<td>b-&gt;</td>
<td>GazeDoc:</td>
<td>---------...x___</td>
<td>[From MR to Pat]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a-&gt;</td>
<td>11 Doc:</td>
<td>Miss:iz Rattigan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d-&gt;</td>
<td>GazePat:</td>
<td>---------...</td>
<td>[From desktop to Doc]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c-&gt;</td>
<td>BodyPat:</td>
<td>x</td>
<td>[Pat lands in chair]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g-&gt;</td>
<td>GazeDoc:</td>
<td>___.</td>
<td>[From Pat to computer]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f-&gt;</td>
<td>12 Pat:</td>
<td>Yes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-&gt;</td>
<td>GazePat:</td>
<td>x___</td>
<td>[Doc]</td>
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</table>
The doctor begins to confirm the patient's identity (a->) while still gazing at the records (b->). The doctor's torso and legs are oriented toward the desk. Very shortly after the patient sits down (c->) and before the completion of the doctor's identity confirmation, the doctor shifts his gaze to the patient from the records (b->). In response to the doctor's gaze shift (which both proposes and solicits engagement), the patient begins to shift her gaze to the doctor from the desktop (d->). Simultaneous with both the establishment of mutual gaze (e->) and the completion of the doctor's identity confirmation, the patient confirms the proposed identity (f->). As the patient responds, the doctor shifts his gaze from the patient to the desktop computer (g->) and then produces "Right." (h->), which registers and accepts the patient's confirmation and proposes closure of the identity-confirmation sequence (Schegloff, 1995).

The doctor again uses practices of talk, gaze, and body orientation to communicate the temporary nature of his engagement with the patient embodied and the dominant nature of his engagement with the patient in bureaucracy. As with greetings and invitations to sit down, the act of confirming or searching for a patient's identity routinely occurs before and is preparatory to dealing with the chief complaint. The doctor's gaze and body orientation again allow him to simultaneously accomplish a collaborative task preparatory to dealing with the chief complaint and communicate his continued lack of readiness to deal with that complaint. In response to the doctor's disengagement from her embodied self (g->), the patient shifts her gaze from the doctor back to the desktop (i->). By shifting her gaze back to the field of bureaucratic action, she again communicates a diminished state of engagement with the doctor embodied and an enhanced state of engagement with the doctor doing bureaucracy.

Immediately after producing "Right," the doctor requests permission to input patient information into the computer (h->). As the doctor begins his request, he shifts his torso to squarely face the computer (j->); he is gazing at the computer (k->). Thus, the doctor requests permission while his gaze and body orientation communicate disengagement from the
patient embodied and engagement with the noncollaborative action of preparing to use the computer. Nonetheless, the doctor’s request initiates a collaborative action by soliciting a response from the patient. His gaze and body orientation communicate that the act of requesting permission is temporary and secondary relative to the long-term and dominant noncollaborative act of using the computer. After the patient grants permission (l->), the doctor begins to type on the keyboard (m->). Throughout the doctor’s request, the patient’s granting, and the extended ensuing lapse (n->), the patient gazes at the desktop. The doctor and patient again coconstruct a continuing state of incipient talk in which the patient waits for the doctor to initiate a next bit of talk while the doctor prepares to deal with her chief complaint.

Determining the chief complaint. The shift from the activity system of opening a consultation to that of history taking regularly occurs when doctors solicit patients’ chief complaints (see Beckman & Frankel, 1984; Coupland et al., 1994; Heath, 1981). During this sequence, doctors regularly shift both their gaze and body orientation to patients (see Data Fragment 1D).

Data Fragment 1D: Breathing (Nonverbal)

| c-> BodyDoc:  | x:xxxxxxxxxxxxxxxx | [Shifts legs, torso,] |
| d-> GazeDoc:  | -----------x---- | [head to Pat] |
| a-> 18 Doc:   | hhhhhhhhhhhhhhh So, what's the problem= | [To MR, to Pat] |
| b-> GazePat:  | --x------------ | [From desktop to Doc] |

The doctor begins his turn by inhaling (a->), which projects a turn of talk. The patient responds to the in breath by shifting her gaze from the desktop to the doctor (b->), communicating her readiness to act as a recipient. However, when the patient’s gaze reaches the doctor, the doctor’s gaze and body orientation still communicate full engagement with the computer. She continues to gaze at the doctor and wait for his engagement. As he draws breath, the doctor begins to shift his legs, torso, and head (but not his gaze) from the computer to the patient (c->). Shortly after he begins to shift his body, he shifts his gaze from the computer to the records, which are on the desktop (d->). As the doctor begins the verbal portion of his turn, he begins to shift his gaze from the records to the patient (d->). Before completing his turn of talk and for the first time during the opening, the doctor’s gaze and body orientation communicate
full engagement with the patient embodied. Figure 3 depicts the videotape frame occurring at the completion of the doctor’s turn.

As noted earlier, because people’s frame of dominant orientation communicates the locus of their long-term, dominant actions, shifting this orientation can communicate a shift in dominant actions (C. Goodwin, 1981; Kendon, 1990c). In Data Fragment 1D, when the doctor shifts his body orientation away from the computer and the records to the patient, he communicates a shift in dominant involvement away from a locus of bureaucratic action involving preparing to deal with the chief complaint to a locus of interpersonal action involving soliciting the chief complaint. The doctor communicates a shift away from the larger activity system of opening a consultation to that of history taking. The doctor’s turn, “So: what’s the problem,” initiates a sequence of talk and makes relevant a disclosure of the chief complaint, which the patient begins to provide at line 20.

A Deviant Case

So far, it has been demonstrated that when doctors use gaze and body orientation to communicate disengagement with patients embodied and
engagement with noncollaborative actions preparatory to dealing with the chief complaint (i.e., engagement with patients in bureaucracy), they communicate the nonrelevance of engaging in collaborative action with patients (most importantly talk). Furthermore, it has been demonstrated that patients understand doctors’ nonverbal behaviors in this way and collaborate with doctors’ nonverbal proposals of disengagement by silently accomplishing other noncollaborative actions preparatory to dealing with the chief complaint (e.g., closing the door, sitting down) and by waiting for doctors to communicate their readiness to deal with the chief complaint. Opening 2, involving a mother and her son (the patient), represents a deviant case. At line 11, the mother initiates an action that requires the doctor’s collaboration despite the fact that the doctor’s gaze and body orientation communicate disengagement from the mother. In addition, the mother proposes to deal with the chief complaint before the doctor has completed the tasks that are preliminary to and preparatory for dealing with the chief complaint. The office layout is identical to that in Opening 1.

Opening 2: Very Bad Cough (Nonverbal)

01 ((Mother and son informed that they are next!))
02 Mom: ((Knock Knock=Knock=>Knock=Knock<))
03 (0.1 seconds)
04 Doc: Come in::
05 (1.5 seconds)
06 a-> Mom: Hello doctor=i[t’s me] again::n,=hh huh huh
07 Doc: [ “Hi” ]
08 (1.2 seconds)

GazeDoc: __________________________ [Mom]

b-> 09 Mom: It’s this one this time
GazePat: ________________ [Doc]

c-> BodyDoc: x::0 [Shifts legs, torso to center of desk]
d-> GazeDoc: , , --- [To MR holder on right side of desk]
e-> 10 (1234) [0.4 seconds]
GazePat: ___ [Doc]

GazeDoc: __________________________________________ [MR holder]
f-> 11 Mom: .tch (1234567) A very bad cough::=hhhhhh
GazePat: __________________________________________ [Doc]

12 (0.3 seconds)

13 Doc: Now you’re::
14 (0.2 seconds)
15 Mom: Meyer.
16 (0.3 seconds)
17 Doc: Ye::[s. ]
18 Mom: [Ro]ber[t (Meyer).]
19 Doc: [Yes yes yes]s yes:: yes::
20 (0.4 seconds)

h-> 21 Mom: A very bad cough:=I had to call the doctor...
As the mother and son walk into the office, the mother introduces herself with the indexical "it's me again," (a-) and indicates that her son is the patient with the indexical "It's this one this time" (b-). Neither of these formulations is sufficient to provide the doctor with the patient's bureaucratic identity—a prerequisite to dealing with the chief complaint. On completion of the mother's turn at line 9, the doctor simultaneously shifts his legs and torso to the center of the desk (c-) and shifts his gaze from the mother to the records file holder (d-), which is positioned on the right side of the desk. By the completion of the silence (e-), the doctor's gaze and body orientation communicate full disengagement from the mother and full engagement in searching for the patient's records.

At this point, the mother, who is still standing, initiates a turn of talk (f-). The mother displays an orientation to the doctor's disengagement by beginning her turn with the clicking sound "tch" and then pausing for seven-tenths of a second, both of which are common conversational practices for attempting to obtain a recipient's engagement (C. Goodwin, 1981). Without obtaining the doctor's engagement, the mother nonetheless continues to disclose her son's chief complaint: "A very bad cough."

Rather than addressing the mother's disclosure of the chief complaint, the doctor continues to gaze at the records file holder and verbally searches for the mother's identity (g-). In doing so, he demonstrates his continued engagement with the action of searching for the records. Because the doctor's identity search is not relevant to the mother's disclosure of the chief complaint, it can be understood as doing the job of ignoring or sequentially deleting the mother's disclosure of the chief complaint (see Lerner, 1988). After the patient's identity has been confirmed (lines 15-19), the mother demonstrates an orientation to the doctor's deletion of her disclosure by redisclosing the patient's chief complaint (h-). The fact that the mother reuses the same words from her initial disclosure ("A very bad cough.") is evidence that the mother is redoing the original action (Schegloff, 1996a).

Opening 2 contains exceptions that prove the rules. By searching for the mother's identity as a deletion of her initial disclosure of the chief complaint, the doctor communicates at least two things. First, he communicates that mother-initiated actions will not be treated as immediately relevant if they are not relevant to the action(s) in which the doctor communicates engagement (i.e., searching for the records) and if the doctor is communicating disengagement from the mother in collaborative action. Second, he communicates that confirming the patient's identity and locating the appropriate records are necessarily preliminary to and preparatory for the action of dealing with the chief complaint.
DISCUSSION

During the openings of British general-practice consultations, doctors and patients perform regular tasks to prepare for dealing with the chief complaint. Doctors greet patients, get them to sit down, secure their identity, and adequately review the records. Patients greet doctors, close the door, sometimes rearrange garments or other belongings, sometimes situate children, and sit down. As doctors and patients work their way through openings, they must deal with at least two interactive problems: (a) how to accomplish necessarily noncollaborative tasks (e.g., patients closing the door, doctors reading the records) amid necessarily collaborative tasks (e.g., greeting, confirming patients' identities) in an environment where both interactants are copresent and working within a common activity system (i.e., opening a consultation) and (b) how to determine each other's readiness to deal with the chief complaint. The number and nature of the bureaucratic tasks that doctors must accomplish make the latter problem more salient to patients. The interactional asymmetry whereby doctors routinely initiate the sequence in which patients disclose their chief complaint is best explained not as the result of doctors' imposition of power (and patients' acquiescence to power) but rather as the result of doctors' and patients' regular interactive solutions to these two interactive problems. Both interactive problems are solved primarily with practices of gaze and body orientation.

During openings, doctors and patients do the following: (a) use gaze and body orientation to communicate levels of engagement with and disengagement from courses of action and therefore with each other; (b) arrange segments of their body to have divergent orientations to communicate multiple frames of engagement and therefore simultaneous engagement with multiple courses of action; and (c) use lower-body segments to more strongly communicate the frame of space wherein their long-term, dominant actions are located. In Opening 1, as the patient entered the office, the doctor's gaze and body orientation were convergently organized and oriented toward the medical records and a desk, respectively. This communicated the nonrelevance of collaborative action between doctor and patient (most importantly talk). Throughout the opening, the doctor engaged the patient in a series of collaborative actions preparatory to dealing with the chief complaint: He greeted the patient, invited her to sit down, confirmed her identity, and requested her permission to use the computer. On each of these occasions, he shifted his gaze to the patient but maintained his lower-body orientation toward the desk. This communicated that his engagement with the patient was temporary and secondary relative to his long-term and dominant engagement with actions preparatory to dealing with the chief complaint. On completion of each collaborative action, he shifted his gaze back toward the desk area, once
again communicating full disengagement from the patient in collaborative action and full engagement in noncollaborative actions preparatory to dealing with the chief complaint. In response, the patient used her gaze and body orientation to communicate alignment with the doctor’s disengagement and accomplished her own noncollaborative actions. In other words, doctor and patient coconstructed interactional spaces in which each could accomplish necessarily noncollaborative actions. When the patient completed her tasks, she waited for the doctor to communicate his readiness to deal with the chief complaint.

Opening 1 represents a recurrent pattern in the larger database wherein doctors move from communicating disengagement with patients embodied and engagement with patients in bureaucracy to communicating temporary engagement with patients embodied; doctors then accomplish an opening task preparatory to dealing with the chief complaint and return to communicating disengagement with patients embodied and engagement with patients in bureaucracy. Patients recurrently participate in the opening tasks and then wait for doctors to initiate a new sequence.

The asymmetry whereby doctors initiate the majority of opening sequences, including the sequence wherein patients disclose their chief complaint, is thus most proximately explained as a collaborative and contingent product of doctors’ and patients’ solutions to the interactional problems associated with preparing for and determining each others’ readiness to deal with the chief complaint; these solutions primarily include the deployment of and orientation to practices of gaze and body orientation. This finding coincides with Heath’s (1986) observation that patients are unlikely to know exactly when doctors are ready to deal with the chief complaint and thus wait for and allow doctors to solicit the chief complaint. This interactional explanation for asymmetry is not necessarily incompatible with a traditional power explanation. That is, one might argue that doctors and patients regularly behave the way they do, reproducing interactional asymmetry, because doctors are powerful and patients are subordinate. However, it is important to realize that although doctors and patients consistently demonstrated a verbal and nonverbal orientation to accomplish tasks relevant and preparatory to opening consultations, they rarely demonstrated an orientation to theoretical characterizations of power. Although a traditional power explanation can be laminated over the present interactional explanation, this would be without grounding in the specifics of the verbal and nonverbal interactions carried out.

This study also has implications for research on nonverbal communication. First, it demonstrates that doctors’ and patients’ understandings of gaze and body orientation are interrelated. For instance, when doctors’ gazes are oriented toward patients but their torsos and legs are oriented toward a desk and the records, their gaze orientations communicate that
they are currently engaged with the patient, but their body orientations communicate that this engagement is temporary and secondary relative to their long-term, dominant engagement with the action of reading the records. Alternatively, when doctors' gazes and body orientations are convergently organized toward patients, they communicate that their engagement with patients is stable, long-term, and dominant. In each instance, doctors' gaze orientations are understood differently depending on their body orientations. This is supported by Mehrabian (1967), who found (in a nonmedical context) that the amount of time senders maintained head orientations toward receivers was positively associated with perceptions of senders' positive attitudes toward receivers—but only when senders' bodies were also oriented toward receivers. This suggests that studies concerned with either gaze or body orientation should measure and vary both variables (cf. Bensing et al., 1995) and should do so in and of the variables themselves rather than solely as aggregated components of larger-order variables.

Second, this study suggests that doctors' and patients' understandings of gaze and body orientation are themselves interrelated with the courses of action in which interactants are engaged and the larger systems of activity in which those actions are situated. For example, a regular occurrence during openings is that doctors shift their gaze away from patients to the records. Without considering the relevant actions and activities involved, prior research (e.g., Mehrabian, 1968a, 1968b) might predict that patients would understand doctors' removal of gaze as a negative expectancy violation (see Burgoon, 1978, 1983, 1992). However, this study argues that patients have a distributed existence and are present in their physical bodies and in entries in the records. The action of reading the records is both relevant and preparatory to dealing with the chief complaint and thus to completing the larger activity system of opening a consultation. Therefore, contrary to the implications of prior research, it is likely that patients understand doctors' gaze shift away from them and to their records as relevant to, appropriate for, and expected within the activity of opening a consultation.

Studies of gaze and body orientation in doctor-patient interaction have, in fact, produced several counterintuitive findings. For instance, the amount of time that doctors maintain eye contact with patients has been found to be negatively associated with perceptions of doctors' rapport with patients (Harrigan & Rosenthal, 1986) and with patients' satisfaction and understanding (Larsen & Smith, 1981). Harrigan and Rosenthal (1986) explained their findings by hypothesizing that doctors' complete engagement with patients themselves and complete disengagement with the patients' records seemed to convey the doctors' lack of concern with their task. Future research on nonverbal behavior should include analyses of
the systems of action and activity in which the nonverbal behavior is deployed and how these systems affect interactants' attitudes.

Third, this study poses several problems for existing forms of measurement of gaze and body orientation. Traditionally, these behaviors have been measured in terms of their presence or absence relative to interactants. However, because patients have a distributed existence, there will be moments when doctors' gazes and body orientations are simultaneously present and absent relative to patients—that is, present relative to patients in bureaucracy but absent relative to patients embodied or vice versa. This is further complicated by the fact that doctors can arrange segments of their bodies to have divergent orientations, simultaneously communicating different levels of engagement with multiple aspects of patients.

A second problem with existing forms of measurement is their lack of sensitivity to whether the presence or absence of gaze or body orientation is relevant or nonrelevant to current actions and activities. For example, different types of documents have different levels of relevance for the activity of opening consultations, and attitudes concerning engagement with documents will probably vary with such relevance. For instance, in another opening from the database, a patient unexpectedly enters the office only to find the doctor gazing at and filling out paperwork unrelated to preparing to deal with the chief complaint. The doctor explains that he was engaged in the paperwork because he was not warned of the patient's arrival and immediately abandons the paperwork, invites the patient to sit down, and begins to search for the records. In this case, as the patient enters the room, the doctor's gaze is not simply absent from the patient but absent in a way that is not relevant to the activity of opening a consultation (as opposed to the relevant action of reading records). Thus, in addition to measuring the presence or absence of gaze or body orientation, it is also necessary to measure whether engagement or disengagement is, at the moment of measurement, oriented to by the interactants as relevant or nonrelevant to current actions or activities, and how this relevance affects interactants' attitudes.

A final problem is that gaze and body orientation have traditionally been measured in terms of the amount of time that they are present or absent across entire interactions. This study suggests that the duration of these behaviors should be measured relative to courses of action and systems of activity. Actions and activities are largely organized by and performed through sequences of turns of talk (Schegloff, 1995). At least with regard to gaze orientation, research has found that there are specifiable locations within turns, such as beginnings and endings, where the presence or absence of gaze is normative or not (C. Goodwin, 1981; Kendon, 1990b). Therefore, even within a single turn of talk, attitudes concerning the presence or absence of gaze will vary.
In conclusion, doctors' and patients' practices of gaze and body orientation are highly consequential for the organization of interaction during the activity of opening a consultation and for interactants' attitudes about talk and other behavior during that activity. Although this study examined only the activity of opening a consultation and did so only within a British context, there is evidence that gaze and body orientation are used and operate similarly within other activities and in American contexts (see Heath, 1986; Psathas, 1990). Future research must explicitly examine the effects of talk, gaze, and body orientation on the organization of interaction during other activities that regularly compose doctor-patient consultations, such as history taking, physical examination, diagnosis, treatment, and closing.

APPENDIX

The data have been transcribed according to conventions developed by Gail Jefferson (see "Transcript Notation" in Atkinson & Heritage, 1984, pp. ix-xvi) and C. Goodwin (1981).

Verbal Conventions

Doc: Speaker identification: Doctor (Doc), patient (Pat), and mom (Mom).
[overlap] Brackets: Onset and offset of overlapping talk.
= Equal sign: Utterances are latched or run together, with no gap of silence.
(0.0) Timed pause: Silence measured in seconds and tenths of seconds.
(.) Parentheses with a period: A micropause of less than 0.2 seconds.
: Colon(s): Preceding sound is extended or stretched; the more colons, the longer the stretch.
. Period: Falling or terminal intonation.
, Comma: Continuing or slightly rising intonation.
? Question mark: Rising intonation.
word Underlining: Increased volume relative to surrounding talk.
"soft" Degree signs: Talk with decreased volume relative to surrounding talk.
>fast< Greater than/less than signs: Talk with increased pace relative to surrounding talk.

h Superscripted periods preceding h's: Inbreaths; the more the longer.
hh: Outbreaths (sometimes indicating laughter); the more the longer.
hah/heh/huh Laugh token: Relative open or closed position of laughter
(that/hat) Filled single parentheses: Transcriptionist doubt about talk.
((Cough)) Filled double parentheses: Scenic details or an event/sound not easily transcribed.
Nonverbal Conventions

<table>
<thead>
<tr>
<th>Convention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>x:::0</td>
<td>Xs, colons, and o's: Onset, actualization, and offset of a body movement.</td>
</tr>
<tr>
<td>....</td>
<td>Periods: Speaker is moving gaze toward another interactant.</td>
</tr>
<tr>
<td>'---------'</td>
<td>Commas: Speaker is moving gaze away from another interactant.</td>
</tr>
<tr>
<td>______</td>
<td>Underlines: Speaker is gazing at another interactant.</td>
</tr>
<tr>
<td>x</td>
<td>X's: The point at which a speaker's gaze arrives at another interactant.</td>
</tr>
<tr>
<td>----------</td>
<td>Hyphens: Speaker is gazing at an object (i.e., not an interactant).</td>
</tr>
<tr>
<td>(12345)</td>
<td>Numbers in parentheses: Running counter of tenths of seconds; asterisks signal one full second.</td>
</tr>
<tr>
<td>MR</td>
<td>MR: Shorthand for the patient's medical records.</td>
</tr>
</tbody>
</table>

NOTES

1. Research has examined the association between gaze and body orientation and background variables, such as patient characteristics (Street & Buller, 1988) and outcome variables, such as patient satisfaction (Bensing, Kerssens, & van der Pasch, 1995; Comstock, Hooper, J. M. Goodwin, & J. S. Goodwin, 1982; Larsen & Smith, 1981), patient understanding (Larsen & Smith, 1981), doctor affiliative and dominance (Street & Buller, 1987), doctor rapport (Harrigan & Rosenthal, 1986), doctor awareness of patient health (Bensing et al., 1995), doctor experiencing (Davis & Hadiks, 1994), and quality of psychosocial care (Bensing, 1991).

2. Kendon (1990c) referred to this as a transactional segment.


4. For other examples, please contact the author at University of California, Los Angeles, Department of Sociology, 405 Hilgard Avenue, Los Angeles, CA 90095; e-mail: jdr@ucla.edu.

5. Patients may have one or more complaints and do not always mention their chief complaint first (Lipkin, Frankel, Beckman, Charon, & Fein, 1995). For the purposes of this study, the term chief complaint refers to the initial reason patients provide for coming to the doctor.

6. Doctors read the records first to appropriately deal with the chief complaint. As Heath (1982) noted, "The doctor needs to discover whether the patient is visiting the doctor for the first time with a particular complaint or whether the patient has been asked to return to the doctor following a previous consultation" (p. 58).

7. Heath (1984) demonstrated that when doctors solicit the chief complaint prior to patients actually landing in the chair, patients will delay their telling until they have sat down. In the present data, doctors routinely wait for patients to sit down or demonstrate an intention to sit down prior to soliciting the chief complaint.
8. This nicely demonstrates that talk can be used to communicate engagement independent of gaze and body orientation.

REFERENCES


