Space, Materiality and the Contingency of Action.

A Sequential Analysis of the Patient's File in Doctor-Patient Interactions.

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This paper has been published in Discourse Studies, 11/3, June 2009, pp. 285-303 by Sage Publications Ltd, All rights reserved. © SAGE Publications Ltd, 2009.
It is available at: http://dis.sagepub.com/content/11/3/285
[the page breaks of the version published in Discourse Studies are given in square brackets]

Keywords: space, materiality, doctor patient interaction, thing, ethnomethodology, topic development, topic change, knowledge

Abstract: Focusing on the multi-dimensionality of interactional settings, this study analyzes how the material world is a significant factor in the sequential co-production of the video-taped doctor-patient interactions. The analysis shows how a material artifact, the patient's file, is relevant in two ways: (a) As a device which is employed in the sequential organization of the interaction. The patient's file is being used in the contexts of topic development and topic change. (b) The file with its specific physical and symbolic features is being co-produced and contested by both actors as a knowledge reservoir. Further inspection of the interactions in concert with theoretical reflections of the role of space and materiality suggests that interactions should be interpreted as happening in spatially arranged constellations of material objects and actors. In these both rigid and flexible constellations boundaries are established, access is distributed, and meaning is solidified.

Since its early beginnings, protagonists coming from the social sciences have stepped over the borders that are established by the name of their discipline. They have looked at more than purely social facts, at more than the interactions between two or more people, and at more than pure social systems. In the introduction to his general history Ibn Khaldun (2005) demonstrated how spatial and material factors have an impact on the way nomads and city dwellers in 14th century Maghreb live and inter-

act; Henri Lefebvre (1991), Bruno Latour (1987; 1993) and more recent dealings with performativity, for example in Pickering (1995) and Thrift and Dewsbury (2000) are all exemplary in thinking the social together with the spatial/material. This is also true for the work of conversation analysts and ethnomethodologists. Deploying concepts and methods that were [286] developed in conversation analysis, I want to demonstrate how the material world reaches into social interactions, and consequently fill in some of the physical details on our mental maps of the social. All human action is embedded into the material world around it. However, in the social sciences and in the study of talk-in-interaction the material world sometimes disappears; what remains might be a free floating stream of transcribed talk or an abstract social system that reproduces itself according to its own set of rules. Although this particular work of disembedding action from its more or less immediate environment serves the purpose of producing a more clearly cut analysis quite well, and sometimes seems to be necessary to actually filter out the rules according to which we act and talk, I want to follow the other, less clear, more curvy path of mixing the physical and the social. By embedding talk in the material world the analysis opens its perspective to the dirt, as in Goodwin (2000a; 2000b), and the fuel, as in Hutchins and Palen (1997) that grind through and propel everyday life and interaction.

In the ethnomethodological tradition the focus is on the explicit uses that actors make of certain interactional devices. 'Displaying' is the central concept here; via mutual displays the actors coordinate and negotiate their actions. How does the material world come into (dis-)play in this context? The short answer to this question is that it is referred to by the actors. The archeologists in Goodwin's study move the dirt around below the color chart which they are using to classify the dirt's color. They point to holes on the chart and move the dirt accordingly. The pilots studied by Hutchins and Palen follow the path of the engineer's hand over the control panels as he talks to them about a potential leak in the fuel system of the Boeing 727. These actors use the material world around them to display to co-present others what they are talking about and what is at stake in the current situation. What differentiates these referrals to objects and spaces from other referrals? Referrals can be made by anyone in a conversation. Each participant can refer to certain rules and make use of conversational devices like exclamations, tokens of agreement or disagreement, and so forth. Referring to material objects is somewhat different from these kinds of referrals; the actor referring to the object usually has to be in a certain spatial position to be able to do this. In his study on action and embodiment, Goodwin (2000a) also analyzes the behavior of girls who start an argument about the rules of the game of hopscotch, which they are currently playing. He describes the importance of the positioning that the actors take to another; the girl that feels she is being cheated stops the other girl by way of stepping almost into the hopscotch grid; thereby displaying her claim through the spatial positioning of her body. Access to relevant objects/spaces does not seem to be too problematic in this case. However, this can be different in other settings. The cockpit of an airplane, for example, restricts the access of the actors to panels and controls, which can be properly read and manipulated only by the person sitting in front of them. The cases which I am studying in this paper,

doctor-patient interactions, also feature specific barriers that hinder access to things and spaces in the setting. However, the focus of this paper lies neither on the potential difference between institutional and everyday settings nor do I want to explore doctor-patient interactions as a specific setting. Instead, [287] I want to analyze the different ways in which a material artifact, in this case the patient's file, is used in a conversation. In the course of the analysis it will become clear in how far both setting and the special significance and meaning of the object that is under scrutiny are relevant for their analysis.

One of the most remarkable features of the fine grained method employed by conversation analysis is that it makes features and processes visible that are too subtle too be seen with other methods. This is particularly remarkable because, as I mentioned above, conversation analysis is concerned with explicit displays and reactions to the displays made by co-present others. Perhaps this could be interpreted as a contradiction; on the one hand there are open displays of intentions, on the other there are subtle, almost hidden processes affecting the development of an interaction. It seems that this is an issue of temporality. Most interactions go along very quickly and continuously. A pause of more than half a second is a long time on a talk-in-interaction scale. Reactions to statements and displays of others have to be performed quickly to keep up the flow of the conversation or interaction. New cues are constantly coming into play and request adequate moves by both participants. The combination of all of these factors requires considerable time for more explicit observation and perhaps even reflection of these techniques. It is through recordings and transcriptions that the scale changes so that times and spaces for analysis and reflection are created. This is especially true when the analysis is concerned with gestures and spatial positionings. The biggest problem with spatiality in interactions is its multi-dimensional character. Recording and analyzing gestures and spatial positioning is difficult, because they do not only encompass a linear stream of action, but also a relational component. The use of video recordings makes it possible to capture and study many of these components, and blow up the scale again to enable an analysis of real time interaction-in-space. Heath and Hindmarsh (2002) provide a valuable discussion of the potential benefits arising from the use of video recordings – they also work with doctor-patient interactions as examples, analyzing the role of the patient's medical record in the opening of a doctor-patient interaction. From my perspective, the most interesting aspect of this analytical empowerment is that it opens access to a realm in which the body, space, materiality, and meaning all intersect – a realm in which the obstacle for doing something can be a question of symbolic representation but also a physically existing wall. A mixture of very diverse factors generates the constellations in which actors produce reality for themselves and for others. Spatial relations and the material quality of objects (their mass, texture, smell, opacity, etc.) are some of the more stable elements of these constellations even though they do not always find their way into the social sciences.

It is this special kind of rigidity inherent to the spatial/material setup in which people act that lies at the heart of my interest. It is hard to challenge the armrest of a chair that restricts the movement of the person sitting in the chair, it can be difficult

to see the fine print of a contract that is lying on a desk in a room that is not well-lit if old age has had a detrimental effect on eyesight, and it could be difficult to talk about the status of one's therapy if the doctor you are talking does not display that he has read the file on which his hands rest. [288] This does not mean that space and matter are static, not changeable by human action, or that they occupy a clearly predefined role. As Lefebvre (1991) puts it, all action is situated in a triad of spatial practices, representations of space, and spaces of representation; space is being produced through our actions and action is produced in specific spatial settings.

How do people cope with this special character of their environment? How can – and do – they change the constellations of which they are part? Do actors deal with their spatial/material environment according to 'scripts', for example by trying to change the physical setup first (either by repositioning themselves or others/objects), and, if that does not work, do they 'fall back' to changing the representational setup or use some other technique to cope with the situation? These are some of the important questions that are raised by systematically embedding the finer details of human interaction in space and by paying attention to the material qualities of the concrete places in which people move and act. It is an exciting venture to ask if agreement tokens, the way a topic changes, the ever-present potential of confusion and the matching availability of repair mechanisms, which are observable in talk-in-interaction, also have their equivalents in the way we deal with the material world around us. In this paper I will only be able to provide a few isolated clues that hopefully serve to get in closer touch with these relations.[1]

Before I continue with the actual analysis, I want to make a few remarks regarding the special significance of the body. For an analysis of interactions that includes the spatial and material embeddedness the body is of extraordinary significance. The examples I have given so far all indicate this: the spatial position of bodies, the way bodies or parts of them move through a spatial setup, the way that actors-as-bodies, through their skin and other perceptual organs, encounter and manipulate their environments – interactions are accomplished through the physical presence and acting of the body. Spatial distance, obstacles to movement and perception affect the bodies of the actors and it is through their bodies that the actors in turn reconfigure the social, spatial and material constellations that they are part of. Talk, discourse, and interactions in general are intrinsically bound to the materiality of the world we live in; the actors-as-bodies are both objects that are positioned in and guided through their environment in specific ways, and subjects that act to change their position, the position of others and the spatial configurations themselves. However, the bodies-as-subjects are confronted with many material and spatial limitations or restrictions to their actions.[2] It is an open and perhaps misleading question if the spatial and material aspects of interactional constellations are less obvious and/or less

1 In Frers (2006) and Frers (2007) I have studied human-technology interactions with regard to spatial arrangements and social control in railway stations and ferry passenger terminals.

2 The focus on perception and corporeality puts this work close to Merleau-Ponty's phenomenology (1962).

accessible as objects of reconfiguration to the actors than 'soft' factors such as symbolic meanings, the turn-taking structure etc. This ethnomethodological exploration of how the material world is treated by the actors themselves may provide some clues to answer, dismiss or requalify the question about the difference between social and material aspects of interactional constellations.

In the following part of this article I will examine the data I had available, video recordings of doctor-patient interactions. Still images and a few special transcription techniques are going to be used to represent at least some of this recorded [289] complexity in print. I will focus on the way one particular object, the patient's file, is used in these interactions. Looking at the sequential placement of referrals to the file I want to demonstrate the function it has regarding the development and the changing of topics. After spelling out the relation of the patient's file to these aspects of topic organization I will get back to the theoretical and methodological frame which I formulated in the beginning of the article and I will try to develop an understanding of the specific social and material significance of the patient's file.

The Patient's File – Sequential Use of a Material Object

There are multiple ways in which referring to the file could be examined with regard to the rest of the interaction. In this case I will concentrate on the relation between referring to the file and the development of topics in the interaction, which is in itself a complex aspect of conversations.[3] Topic organization can proceed in many ways; as I will show, referring to an object either by touch or by other moves can be a way for interactors to develop 'topic talk.' In looking at my transcripts and recordings two different constellations emerged out of this context. On the one hand, referring to the file accompanies the development of topic talk in several ways; on the other hand, it appears in sequences where a change in topic is produced by the actors.

Transcription

To catch some of the complexity of the recorded interactions I roughly transcribed those gestures that accompanied referrals to the patient's file, thereby adding information to the already transcribed talk. By 'roughly' I mean that I did not transcribe every movement that was discernible for me, but that I transcribed those gestures which were most likely perceivable for both participants, i.e. I neglected minimal movements and those happening out of the line of sight of the participants. Furthermore, I did not transcribe the exact processes of how participants shift their gazes in as much detail as Gail Jefferson did, for example with the data presented in Goodwin (1984) – this seemed unnecessary for demonstrating the use of gestures and moves and their relation to topic talk in the recordings that I use.

3 See J. Maxwell Atkinson and John Heritage (1984: 165-6).

Special Transcription Symbols

italics – Marks transcribed gestures or moves.
\ … \ – The slashes mark the starting and ending of a gesture or move after which the actor returns to her or his former positioning.
1 …=
2 …
3 =…
Whatever happens before the first '=' is followed directly by the actions transcribed after the next '=.' The '…' occurring in between can be either overlapping talk or transcribed gestures that are performed synchronous to the transcribed talk. [290]

Negotiating Accountabilities – Alignment and Resistance

The file is lying on the table in front of the doctor and it is used by the actors in context with the development of talk about a topic. When looking at the following instances however, it will become clear that "topic talk" as an abstract category does not cover the content of the actual negotiations that are being performed. The following two examples demonstrate the ways in which the topic talk is permeated by challenges, by alignments and resistances of both participants. Looking at the recordings, the negotiations which are part of the medical interview are mostly done through talk. At least in the material I worked with, I did not find any instances where gestures or movements[4], in themselves, are elaborating on a topic. However, they seem to display both alignments with the talk produced by the other and resistances against it.

4 In this paper the term gesture should be interpreted as encompassing gestures in a narrow sense, such as pointing at something, but it also includes actions such as shifting the gaze, moving larger parts of the body, and producing mimics. The terms moves or movements will sometimes be used to accentuate this point.

Transcript #1[5]

```
DOC:    I think Doctor Smith from neurology thought
        you we[re depressed.
PAT:          [Mm hm,
        (0.5)
DOC:    Doctor Holiday thought you might've been depre:ssed
        Sometimes when I see you you seem tuh be depressed.
        (0.3)
DOC:    .hh But I noticed what Doc[tor  Jolly   notic]ed as well
     >                            [\glances to file \]
        an' that is some days you don't: seem depressed.
        (1.0)
DOC:    Some days you seem tuh be cheerful an' have uh
        good sense of humor
```

After reporting what the Doctors Smith and Holiday said regarding the possible diagnosis of depression, the Doctor presents a different opinion, that of Doctor Jolly. At the same time that he mentions Doctor Jolly's name, he turns his gaze to the file in which Doctor Jolly's report is located. (The Patient is quite aware that the Doctor [291] has this report. As we shall see in Transcript #4, the Patient inquires about the content of Doctor Jolly's report in an earlier part of the conversation.) In this case, referring to the file can be seen as accompanying talk on the topic of depression diagnosis, and the file is deployed in a context where the doctor elaborates on this topic by presenting information. Information, which stands in contrast to what was said by Doctor Smith and Doctor Holiday – this is marked by the use of the term 'but' at the beginning of the sentence that presents the observations of our Doctor and Doctor Jolly: the Patient sometimes does not seem to be depressed. Before I pro-

5 The stills show the situation as it is at the start of the respective transcript.

ceed to the next example I want to point out that categorizing this sequence as an instance of elaborating topic talk could be problematic. Seeing this as an instance of accountability work offers a slightly different perspective.

Some features of this instance of referring to the patient's file can be characterizing it as part of a news delivery as in Maynard (1997); however, the Doctor already delivered this information earlier in the conversation. He declared that this is "good news" – an evaluation which the Patient consistently resisted. The sequence in transcript #1 therefore can be more accurately characterized as being part of the post-news delivery accountability work regarding the Doctor's assessment of the patient's state; for him it is not a depression in the clinical sense. The Doctor presents arguments why this is not the case, but there are no signs of agreement from the Patient, and she will resist by withholding agreement to the Doctor's evaluation throughout the whole interaction. To strengthen her position of resistance, she produces an agreement token ("Mm hm") when our Doctor states Doctor Smith's opinion, who thinks that the Patient is depressed.

In the next example, the same conversation has turned away from the task of evaluating the patient's depression. Now the focus is on the more practical job of determining which medications should be used to treat the Patient's 'condition'.

Transcript #2

```
DOC:   So we could- discontinue thuh metocrowall:,
       (\1.5 rubs nose with right digit\)                    [292]
DOC:   But because of your heart- problem
       we'd [wanna substitute
PAT:        [And thuh blood pressure=
```

```
PAT:    =(then) I'd haft[a have something-
DOC:                    [uh calcium channel blocking dru:g:h=
      >                 [turns to file
DOC:    =·hhh [Your blood pressure toda:y     [was: one twenty over=
      >       [flips pages &\glances to PAT\  [refers to file
        =seventy eight [which is rather wonderful
      >                [flips pages back and faces PAT
        (2.0)
DOC:    So we could substitute uh calcium channel blocking drug
        for thuh metocrowall, (.) an' we would not expect thuh
        calcium channel blocking drug tuh make you tired or fati:gued
```

While the Doctor develops talk with regard to a change in medication for the Patient, the Patient produces an overlapping utterance, adding another aspect of her physical condition: her blood pressure. This is followed by her saying "I'd hafta have something-" (possibly some medication serving to take care of her blood pressure). This utterance, in turn, is overlapped by the next turn of the Doctor, who finishes his earlier turn, saying "we'd wanna substitute" … "uh calcium channel blocking dru:g:h". After this turn, the Doctor displays his alignment to what the Patient said; he provides information about her blood pressure, and he retrieves this information from the file, reading the measurements to the Patient (announcing that this is "rather wonderful"). What is remarkable about this instance is that the Doctor actually orients himself to the Patient's concern with her blood pressure before he produces talk on this subject. Parallel to finishing his turn with "uh calcium channel blocking dru:g:h" he turns to the file, from which he will read the blood pressure measurements about two seconds later. Furthermore, before he starts reading from the file he employs two techniques for expanding the time period filled by his talk. By stretching the word 'drug' and by audibly inhaling ("·hhh") he creates more time in which he can look up the missing information. Again, this is an instance in which the file is used in the context of the elaboration of topic talk – in this case by orienting to an utterance made by the patient, who contributed an additional aspect of her condition to the topic talk. The elaboration is nicely framed by movements of the Doctor. He orients to the file a short time before he presents the information, and parallel to closing the information sequence regarding the Patient's blood pressure by making an assessment ("which is rather wonderful"), he returns to the state he was in before the sequence started.

Looking closer, it again becomes apparent that the topic talk is once more accompanied by an asymmetry in alignment. The Patient's overlapping utterance is not ignored by the Doctor, therefore it produces an interruption in the treatment recommendation phase.[6] The Doctor displays his alignment to the patient's question about her blood pressure. However, when he concludes that the blood pressure "is rather wonderful", the Patient does resist the Doctor's assessment once more by withholding any kind of agreement. [293]

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6 Compare Heritage/Maynard (2006: 15-19) and Stivers (2006) (both in the same volume) who point out that resistances to treatment recommendations are mostly performed in a "passive" way – in contrast to resistances against diagnoses, in which patients take a more "active" stance.

Topic Change – Bridging with the file

The following sequences are examples of referring to the patient's file in the context of changing the topic of the conversation. In the next transcript we encounter a different conversation with another Patient and another Doctor. In the turns preceding this transcript both actors talked about how much the Patient has to pay for her health insurance.

Transcript #3

```
DOC:    (Boy at least???) [that does seem s[teep.]
                          [\glances away   [    \]
PAT:                                      [An' h]e's over sixty
        five so: ·hh he's on medicare (a[n' increased)=
                                        [faces wall & shifts forward
        =(bec[au-)
DOC:          [Uh huh. An' th[at- that's uh- that's uh different-]=
                             [\DOC waves pen                    \]
PAT:                         [So that would reduce it.
                             [leans back & faces to DOC
DOC:    =uh different arrange[ment.
PAT:                          [Should reduce it uh little.
DOC:    (˚Right. Okay.˚) (·hh)
        ([. . . . .)
     >   [\DOC lifts page in file…
DOC:    Uhm:, tlk ][Alright well look I'll start with an ex=
     >          …\][gestures with right hand
        =ra:y, an:' look at that.
```

The Doctor aligns himself sympathetically with the situation of the patient by saying "… that does seem steep" and looking into the air in a way that suggests some pondering on his part. In the overlaps that follow this display, the Patient suggests a miti-

gating factor to the steep costs; i.e. her husband is on Medicare. Following this, the Doctor produces an acknowledgment token ("Uh huh.") overlapping with the Patient's turn. The Patient stops her turn when the [294] Doctor gives his acknowledgment – he then goes on to elaborate his acknowledgment by saying that her husband being in the Medicare program changes the arrangement, but this elaboration is in turn overlapped by the Patient stating the consequence of this change, i.e. a reduction in cost. During this overlap both actors are moving and gesturing until their mutually overlapping actions end and the Doctor repeats his last utterances – followed by the patient repeating her statement, this time with a shorter overlap of only one syllable. At this point the conversation quiets down and the Doctor closes the topic by producing two agreement tokens and a short, audible inhalation. During the following 0.5 second pause he lifts a few pages in the file (without looking at the file), and after producing an "uhm:" and a smack-like sound he lets the pages drop down and proceeds by gesturing with the hand that he used to lift the pages and, at the same time, saying that he will start with taking an x-ray. (To have a picture of the Patient's medical problem, which was discussed earlier in the conversation.) Doctor and Patient then go on to talk about when this x-ray should be taken.

There is strong evidence here that puts this sequence into the category of topic change sequences. Before the Doctor refers to the file both actors finish their turns by repeating what they said during the overlapping turns without changing the content of what they say in a sequentially significant way. The content of the talk, the overlaps and the shifting of the Patient's bodily position and all make it apparent that the subject of the cost of health insurance is somewhat awkward to both parties. However, they negotiate the topic by mutual displays of alignment or sympathy regarding this difficult subject.

After the Doctor strongly agrees that the cost is high, the Patient mentions Medicare's reduction of the cost to the Patient ("so that would reduce it"), to which the Doctor agrees. The Patient then says that the high costs are still there, since Medicare "should reduce it uh little" instead of covering a large amount, but this change in formulation is not taken up by the Doctor, who goes on to produce agreement "°Right. Okay.°", thereby closing the topic.

The Patient does not use the following pause to continue talking about the health insurance cost. In the same time, the doctor lifts some pages in the file, produces a "floorholder", see Jefferson (1984: 216-7), "Uhm:, Tlk", and lets the pages drop back. During this phase, which ends talk on the awkward and asymmetric subject of monetary concerns, both participants collaborate in bringing the topic talk to a close. The Doctor then displays his reorients to a new topic, which he introduces with "Alright well". Thereby he providing even further displays of his intention of starting a new topic, as has been demonstrated by Button and Casey (1984: 177-8). The lifting and dropping of pages in the file seems to pre-announce a change in topic

before the doctor displays the upcoming change by verbal utterances.[7] This use of the file in the empty in-between space/time suggests that a thing like the file can be used as a bridging device. The bridging device can be used in co-producing topic change, and it would be interesting to see if one can find instances where the potential pre-announcement of a topic change is responded to by the other participant in the conversation (for example, by taking up the topic him/herself, instead of waiting until the gesturing participant starts talking about the topic). In addition, it is interesting to see [295] how these kinds of bridging devices are being used in the context of shifting to or from particularly touchy subjects. This kind of use can also be observed in the following transcript.

The next transcript will provide another example that demonstrates how referring to the patient's file can be employed in the context of changing topics – however, this time it is the Patient who initiates the change. (In this transcript we return to the conversation featured in transcripts #1 and 2.)

Transcript #4
(The physical outset of this situation is practically identical to the one in transcript #1)

```
DOC:    You wanna: (.) quit working here.
        (1.0)
DOC:    Don't blame ya.
        (4.5)
DOC:    Don't blame ya.
        (1.5)
DOC:    Ya obviously: you feel: strongly about it.=hh
        (8.5)
     >  \PAT glances to and nods at file\=
PAT:    =Tlk (Well) what did Doctor Jolly tell y[ou.
                                                [faces DOC
DOC:    Tlk .hh Well: he said- (.) in thuh letter pretty much:
        what you told me.
        (.)
DOC:    He:- He had uh chance tuh look over your medical records.
        ·hhh before he wrote thuh letter.
```

The Patient, who works in the same institution as the Doctor, wants to quit working there (she said so earlier in the conversation). This topic is taken up by the Doctor, who, after pauses of 1.0 and 4.5 seconds length, says and repeats that he doesn't blame her (for this decision). After another 1.5 seconds pause, in which the Patient continues to resist the Doctor's evaluation, the Doctor produces another display of empathy regarding the Patient's intention ("Ya obviously: you feel: strongly about it.=hh"). This is followed by a long pause of 8.5 seconds in which neither the Patient nor the Doctor move or shift their gazes, simply keeping their positions, the Doctor looking at the Patient, the Patient looking at the (mostly featureless) space in front of her, both waiting. Finally, the Patient turns her head, nods towards the file, and, after

7 This temporal placement of gestures or moves relating to a shift in conversation before verbal markers of this shift is a central feature of Schegloff's discussion in Schegloff (1984). Transcripts #2,3 and 4 are examples of this phenomenon.

making this gesture, asks the Doctor what Doctor Jolly told him.[8] Simultaneous with the completion of this sentence she turns her gaze to the Doctor, who then answers in a somewhat indirect way by saying that Doctor Jolly told him "pretty much" what she told him. In the following turns he goes on to give some more specific information (for example that Doctor Jolly thinks she "does not have a consistent major depression"), entering the diagnostic news delivery.

To wrap it up, this instance displays distinct sequential features of a topic change pre-announced by referring to the patient's file: the former topic is closed by repetitions or assessments, which are not openly challenged but resisted [296] through silence and the withholding of agreement; a (long) pause precedes referring to the file; and both the topic initial elicitor and the next turn are begun with "well". As in the other examples, both parties display awareness of the sequential ordering of topic development or topic change and they place their utterances and their gestures in a way that enables them to interactionally accomplish the sequential organization of their conversations – even in spite of the awkwardness of the situation. A material object, the file, is again the device that allows to bridge the empty space/time and the entering of another topic.

However, the situation in transcript number four is also interesting in so far as it demonstrates that the patient's file, which is 'owned' by the doctor, can actually be used as an interactional device by both the doctor and the patient. In the following part of this paper I will further investigate this issue, and make some suggestions on how the patient's file is used with regard to both its material qualities and its social significance.

Tapping a Knowledge Reservoir

What is the patient's file? What is a 'knowledge reservoir'? Before I go on to examine the relations between the file and both of the participants in the interaction, I want to clarify some potential problems. The file is something that is present as a physical object. It has certain properties, e.g. thickness, being composed of pages, the letters on the sheets in the file are of a certain size, etc. It is located in a specific place in the room in which the actors produce their conversation, e.g. it is lying on the table in front of the doctor, it is at about an arm's length away from the patient, etc. Furthermore, it is also a social object, e.g. it contains social symbols, written language, it was manufactured, it is the property of someone, it is usually used in certain circumstances, etc. However, it is also a social object insofar as it is used by people in certain social settings. In using this object, people reproduce the social aspects of the file. Arguing ethnomethodologically, the meaning of a thing (regardless of it being a physical object or a social relation) actually emerges in the interaction – meaning is something that is accomplished interactionally. The participants are constructing the object, but it has to be noted that they do not construct this object out of a shadow

8 In Heath and Hindmarsh (2002) the doctor shifts his alignment and turns to the patient, in their case to open the interaction.

on the wall or out of thin air. Object and actors are embedded in an environment of physical and social relations. As a physical object, the file will 'resist' attempts to construct or use it as a pocket calculator. As a social object in the sense sketched above, the actors will usually encounter resistance if they attempt to use its pages as handkerchiefs. It becomes apparent that the file as a social and physical object does not determine its possible uses in an absolute, but in a relative way, under common circumstances and in its spatial, historical, and social embeddedness. It offers certain affordances and resistances9 that will influence the ways in which it is used. How this is case should become apparent in the course of the following pages.

To what extent can an object like the patient's file be characterized as a 'knowledge reservoir'? The file contains data that were collected in medical settings, [297] measurements like the patient's blood pressure at a certain time were written down and incorporated into the file, graphs, letters, evaluations of medical staff, and evaluations of conversations such as the ones that are transcribed here fill the pages of the file. The file is the product of efforts conducted by a set of people that includes the patient. I think the file's features as being co-produced and as being a collection of knowledge become apparent in the transcripts printed in this paper.

First, the file is co-produced in the way that was described in the preceding section of the paper: It is placed in the sequences of a conversation and it is placed with regard to the sequential organization of the interaction. As such its use is an interactional accomplishment of both participants.

Second, the file is produced as a knowledge reservoir in that it is used to provide details that have been recorded in the past. (See transcript #2):

```
DOC:   =·hhh [Your blood pressure toda:y     [was: one twenty over=
             [flips pages &\glances to PAT\  [refers to file
       =seventy eight [which is rather wonderful
                      [flips back and faces PAT
```

In this case the Doctor retrieves information from the file by reading from it. The file is a reservoir in that it provides the Doctor with the kind of knowledge that he deploys in this situation: exact, written measurements about the Patient's blood pressure, measurements which he evaluates as being very good. As a knowledge reservoir the patient's file enables the person referring to it (the doctor) to complement his or her telling of a 'fact' or information.

Third, the file is a produced as a knowledge reservoir in that it is referred to when a statement is made that links to the knowledge inscribed into the file. (See transcript #1:)

```
DOC:   .hh But I noticed what Doc[tor  Jolly  notic]ed as well
                                 [\glances to file\]
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9 Regarding the resistances offered by physical objects compare Pickering (1995), the notion of affordance has been developed in the so-called ecological approach to cognition, see Gibson (1979), Gibson and Walker (1984) and Costall (1995).

Using a glance at this location in the utterance the Doctor makes a connection between what Doctor Jolly noticed and the file.[10] To be more precise, this connection is of a directional kind; our Doctor does not put the knowledge into the file (for example by writing it down), he refers to the file to account for his diagnosis, a diagnosis to which the Patient does not align herself. The file thereby becomes a reservoir in the sense that it contains information that can be used in the interaction for specific purposes. The doctor is, as Latour (1987: 33) puts it, "bringing friends in", thereby taking his statement out of isolation and connecting it to a wider network of knowledge. The teller can display that this knowledge is (also) in the patient's file, which is an object characterized by its embeddedness in a specific field or network, i.e. the hospital, medicine, measurement, and graphing technology etc. By bringing the file into play, the doctor tries to strengthen his claim vis-à-vis the resisting patient.

Fourth, the patient's file is used and thereby co-produced by both parties. This is of particular interest, because it demonstrates that it is produced as a knowledge reservoir in a flexible way. One could say that in spite of the file belonging [298] to the doctor and being part of his instruments, it is also available for the patient, who can display her stake in the file. (See transcript #4:)

```
       (8.5)
       \PAT glances to and nods at files\=
PAT:   =Tlk (Well) what did Doctor Jolly tell y[ou.
                                               [faces DOC
```

The Patient knows that Doctor Jolly's report is in the file. The report is the result of a set of interactions that happened between them, and she wants to know what this result is. The Patient does not grab the file to read the report herself, instead producing a gesture and an utterance, which are replied to in the following way:

```
DOC:   Tlk ·hh Well: he said- (.) in thuh letter pretty much:
       what you told me. (.)
DOC:   He:- He had uh chance tuh look over your medical records.
       ·hhh before he wrote thuh letter.
       (0.5)
DOC:   ·[hhh An' he does not think tha:]t=hh uh depression is an
     > [\glances to file            \]
       important part of your illness right now.
```

By giving this information (and by, so far, withholding other information) the Doctor orients himself towards the preceding utterance of the Patient; he treats it as a request, to which he aligns himself in the following turns in which he will provide more

10 "Doctor Jolly noticed" is an interesting statement in itself – it seems that Doctor Jolly actually wrote a notice containing the equivalent of the Doctor's utterance "some days you don't: seem depressed".

information about what Doctor Jolly said.[11] That is, he accepts the patient's stake in the file and in turn gives some information. However, at this point in the conversation the Doctor does not look into or orient himself towards the file, thereby withholding bodily alignment to the patient's request for two full turns.

The withholding of bodily alignment becomes particularly interesting when seen in the light of the previous discussion of transcripts 2, 3 and 4, in which the actors aligned themselves to the file before the talk turns to the information that is covered in the file (see also note 5 on Schegloff's discussion of the same temporal prepositioning of gestures). Therefore, the Doctor seems to be reluctant to fully align himself to the Patient's request – a request, after all, which is not directly consistent with a specific 'social property' of the patient's file: it belongs to the doctor or the institution which he represents. This is an interactional piece of evidence for the embeddedness of actors in their environment, in a larger material, social, and historical context – a context in which power relations extend into both actors and objects.

Ethnomethodology, Constellations and the Divide

The analysis that I have performed so far reveals that the interactions between doctors and patients were more than just interactions between two individuals; [299] they were interactions that included the physical environment around themselves, interactions that established spatial distance and closeness, and they were interactions in which artifacts (especially the patient's file, but also the pen that was waved in transcript # 3, the simple, static chair in which the patient leaned forward and backward, or the swivel chairs which allowed the doctors to turn around in their seats) in concert with human action produced a specific and observable stream of interchanges. As I lined out in the beginning of this paper, I examined these interchanges from an ethnomethodological or conversation analytic perspective. I was looking for displays that the actors made, displays to which the actors sequentially, and observably, oriented themselves in their following actions. Some of the displays which I could retrace were dealing with the patient's file. Although the file was spatially positioned in a very similar way in each interaction (always lying on the doc-

11 It could be noted that this information ("what you told me") is not literally congruent with what the Patient said so far. The Patient withholds agreement or alignment with what our Doctor tells her Doctor Jolly said – to the contrary, on one occasion the Patient presents a competing characterizations of her condition (note the "then" and the "but"); again, see Maynard (1997, 2003).

```
DOC:    ·hh And he's (Doctor Jolly) pretty goo:d at (1.0) figuring [these=
PAT: >                                                             [(Then wu-)
DOC:    =things out I think
PAT:    Obviously I've been having::=occasional (.) ·hh periods of
     > depression. but whether they're: (1.0) .hh whether they're
       cau:sed by theh- th- .hh (jumpy legs) an' thuh
       sleeplessness o[r whether: .hh it's- thuh depression=
DOC:                   [(        )
PAT:    that're: (0.6) that's causing ('n)/(it)
```

tor's desk, within reach of the doctor), it was used and referred to under different circumstances and with different effects.

The file, and the other objects present in the interactions or settings, did not impact or shape the interactions in pre-determined ways, instead they were employed in a contingent manner, usually in context with other devices that have been analyzed with regard to their function in the sequential organization of talk-in-interaction (like Jefferson's (1984) floorholder) – so far my analysis is congruent with what Heath and Hindmarsh (2002) propose. Would it then be appropriate to characterize objects and spatial relations – which can be defined as being parts of the interactional setting – as resources12, resources that are accessible for both doctor and patient, serving them as tools employed to achieve specific effects? The evidence which I have found in this analysis makes a different perspective seem more adequate: although material objects and spatial distances can be reconfigured, referred to, and used by both participants, they are relatively stable factors. Stable factors, to use a metaphor taken from the discipline of physics, in a constellation shaping the force-field in which the interaction takes place in several ways:

- Boundaries are established; walls, tables, chairs, windows, mirrors and other objects channel physical movement into specific paths and directions.
- The positioning in relation to other actors/objects establishes distances thereby distributing access to specific objects, and arranging spaces of control – comparable to Goffman's (1971) "territories of self."
- Objects can be solidified collections of meaning, containing for example knowledge generated in scientific contexts.
- Using objects might require specifically qualified actors – technical skill and ownership are two frequently encountered prerequisites.

A comprehensive analysis of social interaction including space and materiality, performed with these factors in mind, would interpret the setting in which the interaction takes place not as something static, a fixed background, but as a constellation of dynamic forces that changes in the course of the interaction, some forces being stronger and/or more stable than others. To me, the advantage [300] of this model seems to lie in the fact that it allows the analyst to conceptualize change and stability. In the frame of this model one can grasp the complexity of multidimensional interactions. It is possible to look at the patient's file as something that is accessible to both doctor and patient, as something that they refer to and imbue with specific and sequentially significant meaning, but it is also possible to look at the patient's file and see that it is owned by the doctor, that it is a reservoir for specifically coded knowl-

12 Heath and Hindmarsh put it this way: "As we have seen, material features of the immediate setting are invoked, referred to, used, noticed, seen, at particular moments, for particular purposes, and they gain their sense or meaning, at those moments from within the action in which they are momentarily rendered relevant. They feature both in the production of action and the ways in which the participants make sense of each others conduct. The immediate ecology of objects and artifacts provides resources for the production of action, and in the ways in which participants themselves recognize and make sense of each others' conduct." (2002).

edge, serves as a link to other actors or networks in a Latourian (2005) actor-network theory sense. This model serves an analytic path that hopefully leads to a more adequate understanding of a dynamic yet stable social reality. A reality in which actors follow specific paths of action, in which they encounter obstacles and forces which they can resist or circumvent or even reconfigure – as the doctors and patients in this text did with the patient's file.

Finally, I want to make a few closing remarks concerning the basic categories 'body', and 'material/social'. The detailedness of the conversation analytic perspective in concert with the possible capturing of the interactional multi-dimensionality provided by video recordings made it possible for me to examine doctors and patients not only as talking actors, but as bodies-as-actors. In the context of this kind of sequential analysis it is neither necessary, nor does it make sense, to construct differences between what people say and what they do. The acoustic as well as the visual and physical dimensions of the interaction are all relevant to what is happening in the offices of the hospital where the video recordings were done. Seen from this perspective, a divide between the material and the social is not existent. Material artifacts, spatial setting, appearances, utterances, history, texts, and actions all taken together create an interaction that, though being contingent in its course and open in its outcome, flows according to specific rules or forces. These are the rules employed in talk-in-interaction, the forces that generate resistances and attractions. Thus a specific symmetry between the material and the social, and between object and subject is being constituted.

Acknowledgements

I would like to thank Douglas Maynard for a thorough introduction to the art of doing conversation analysis and Charles Antaki for encouraging me to get this paper published. Special thanks to Elizabeth Nelson whose sharp prose inspired me and who gave the English in this paper the necessary polish. Finally, I want to thank the anonymous reviewer who offered comments that allowed me to focus even more on what this paper is about.

References

Atkinson, J.M. and Heritage, J. (eds.) (1984) Structures of Social Action : Studies in Conversation Analysis. Cambridge/UK: Cambridge University Press.

Button, G. and Casey, N. (1984) 'Generating Topic : The Use of Topic Initial Elicitors', in Atkinson, J.M. and Heritage, J. (eds.) Structures of Social Action : Studies in Conversation Analysis: 167-90.

Costall, A. (1995) 'Socializing Affordances', Theory & Psychology 5(4): 467-81.

Frers, L. (2006) 'Pacification By Design : An Ethnography of Normalization Techniques', in Berking, H. et al. (eds.) Negotiating Urban Conflicts : Interaction, Space and Control: 245-58.

——— (2007) 'Perception, Aesthetics, and Envelopment : Encountering Space and Materiality', in Frers, L. and Meier, L. (eds.) Encountering Urban Places : Visual and Material Performances in the City: 25-45.

Gibson, J.J. (1979) The Ecological Approach to Visual Perception. Boston: Houghton Mifflin.

Gibson, E.J. and Walker, A.S. (1984) 'Development of Knowledge of Visual-Tactual Affordances of Substance', Child Development : 453-60.

Goffman, E. (1971) Relations in Public : Microstudies of the Public Order. New York: Basic Books.

Goodwin, C. (1984) 'Notes on Story Structure and the Organization of Participation', in Atkinson, J.M. and Heritage, J. (eds.) Structures of Social Action : Studies in Conversation Analysis: 225-46.

——— (2000a) 'Action and Embodiment Within Situated Human Interaction', Journal of Pragmatics 32: 1489-522.

——— (2000b) 'Practices of Seeing : Visual Analysis : An Ethnomethodological Approach', in Leeuwen, T.v. and Jewitt, C. (eds.) Handbook of Visual Analysis: 157-82.

Heath, C. and Hindmarsh, J. (2002) 'Analysing Interaction : Video, Ethnography and Situated Conduct', in May, T. (ed.) Qualitative Research in Practice: 99-121.

Heritage, J. and Maynard, D.W. (eds.) (2006) Communication in Medical Care : Interaction Between Primary Care Physicians and Patients. Cambridge/UK: Cambridge University Press.

Heritage, J. and Maynard, D.W. (2006) 'Introduction : Analyzing Interaction Between Doctors and Patients in Primary Care Encounters', in Heritage, J. and Maynard, D.W. (eds.) Communication in Medical Care : Interaction Between Primary Care Physicians and Patients: 1-21.

Hutchins, E. and Palen, L. (1997) 'Constructing Meaning from Space, Gesture and Speech', Discourse, Tools and Reasoning : Essays on Situated Cognition: 23-40.

Khaldûn, I. et al. (2005) The Muqaddimah : An Introduction to History. Princeton/NJ: Princeton University Press.

Jefferson, G. (1984) 'On Stepwise Transition from Talk About a Trouble to Inappropriately Next-Positioned Matters', in Atkinson, J.M. and Heritage, J. (eds.) Structures of Social Action : Studies in Conversation Analysis.

Latour, B. (1987) Science in Action : How to Follow Engineers and Scientists Through Society. Cambridge/MA: Harvard University Press.

——— (1993) We Have Never Been Modern. Cambridge/MA: Harvard University Press.

——— (2005) Reassembling the Social : An Introduction to Actor-Network-Theory. Oxford: Oxford University Press.

Lefebvre, H. (1991) The Production of Space. Oxford/UK: Blackwell.

Maynard, D.W. (1997) 'The News Delivery Sequence : Bad News and Good News', Research on Language and Social Interaction 30: 93-130.

Merleau-Ponty, M. (1962) Phenomenology of Perception. London: Routledge & Kegan Paul.

Pickering, A. (1995) The Mangle of Practice : Time, Agency & Science. Chicago: University of Chicago Press.

Schegloff, E.A. (1984) 'On Some Gesture's Relation to Talk', in Atkinson, J.M. and Heritage, J. (eds.) Structures of Social Action : Studies in Conversation Analysis: 266-96.

Stivers, T. (2006). 'Treatment decisions : Negotiations between doctors and patients in acute care', in Heritage, J. and Maynard, D. W. (eds.) Communication in medical care : Interaction between primary care physicians and patients: 279-312.

Thrift, N. and Dewsbury, J.-D. (2000) 'Dead Geographies : And How to Make Them Live', Environment and Planning D : Society and Space 18(4): 411-23.