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A *room of one's own*: Moments of mutual disengagement between doctor and patient in the oncology visit

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ABSTRACT

Objective: This paper examines a previously neglected phenomenon in doctor-patient interaction studies, i.e. the achievement of mutual disengagement—a specific state of coordination, in which participants suspend reciprocal gaze and turn into separate axes of involvement. In the specialized setting of the oncology visit, which we consider in this study, mutual disengagement is linked to important tasks that the oncologist has to carry out, notably the scrutiny of the histological exam during the diagnostic assessment phase.
Methods: Our data corpus includes 56 video-recorded oncology visits. We employ conversation analysis to discern how mutual disengagement is achieved, sustained and ended.
Results: Our analysis shows that suspension of mutual engagement is a joint accomplishment that requires intersubjective cooperation. It also reveals that when talk and reciprocal engagement are suspended, intersubjective alignment is more vulnerable to breakdown.
Conclusion: Our findings eschew a characterization of the oncologist as solo arbiter of the interactional exchange. An alignment with the patient is key to the felicitous accomplishment of the visit. We also suggest that a successful medical encounter is not only characterized by harmonious verbal communication, between doctor and patient, but also by felicitous pauses in their joint engagement.
Practice implications: In building *a room of one's own*, the oncologist has the responsibility to co-construct with the patient an experience of interactional attunement and mutual understanding.

1. Introduction

The oncology visit is a complex social and institutional encounter, wherein several activities are carried out, typically organized in stages—each task-centered and implicative of different interactional arrangements, e.g. [1–3]. Therefore, a visit's successful accomplishment depends on continuous doctor-patient coordination through shifts in participation format and turn-taking organization [4,5]. As Robinson and Stivers [5] have pointed out "this accomplishment necessarily involves participants relying on a variety of types of communicative resources (verbal, nonverbal, and social-structural), working in concert and in context" (p. 254). Gaze, posture, gestures, and manipulation of medical instruments and documents index and enact trajectories of engagement and transitions between forms of coordination [5–7].

In this paper, we focus on a specific state of coordination, in which participants suspend reciprocal gaze and retreat into mutual disengagement. We analyze how moments of mutual disengagement between participants are initiated, maintained and closed. We deem these moments worthy of investigation for a number of reasons, notably: (1) despite being characterized by no or minimal interaction between doctor and patient, these moments entail interpersonal coordination and alignment; (2) insofar as they breach the default participation framework of the visit, these moments are somewhat delicate, more susceptible than others to generate misunderstanding, to fail to be established, or to be prematurely closed; (3) they have received considerable less attention in the literature on doctor-patient interaction than verbal phenomena and states of mutual engagement.

We draw from Erving Goffman's work [8], in the 1960s, and that of ethnomethodologists and conversation analysts in the following decades, e.g. [2,3,6], to offer a general description of the oncology visit in interactional terms. As social encounters, medical visits orient participants toward the maintenance of "a single focus of cognitive and visual attention—what is sensed as a single mutual

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activity" [8]. As Heath has shown, such joint attention does not occur automatically in the doctor-patient encounter but is attained through a multi-step process in which doctor's topic-initiating turn follows patient's *display of recipiency*, which elicits speech [9]. Besides, while engagement with each other is the preferential structure of the medical visit there are moments and circumstances wherein full reciprocal engagement is suspended, when participants shift into *mutual disengagement* [8]. Suspension of talk, as a state of coordinated disengagement, typically follows sequence-closing turns and/or is accompanied by withdrawal from mutual gaze, and physical movement. As conversation analysts have shown in a number of other contexts—e.g. classroom, family dinner, research laboratories—the shift away from full engagement is neither automatic nor effortless, e.g. [10–13]. In the context of medical consultations, Heath has examined how exiting mutual engagement at the end of the visit is collaboratively pursued and at times interactionally negotiated by coparticipants [14]. Heath perceptively noticed that nonverbal conduct, notably body movement, that signalled leave-taking occurred after the collaborative production of topic completion, preparing the way for closing greetings and breaking copresence. In Heath's words: "By coordinating the beginning of leave-taking with topic completion, rather than with the conversation's end, the doctor and patient provide a systematic basis for the frequent co-occurrence of the actual breaking of copresence with conversational closure." [14: 40].

Where Heath has provided detailed analysis of the process of coordinated disengagement that yields to the end of the visit, engagement shifts *within* medical encounters—in particular lapses in talk and changes in doctor's axis of involvement—have received no explicit and comprehensive appraisal, with the exception of a study by Newman and associates [15], which examined pauses in general practitioner-patient verbal interaction. The authors detailed "the actions GPs took to achieve the silences they needed for attending to patients' records, and the actions by which conversation was later resumed." [15: 399]. Two main strategies to initiate suspension of talk, often combined with each other, were identified: (1) a bodily shift to prepare to reading and writing; and (2) a summary token that brought the current topic to a closure. Patients were observed to orient collaboratively to the incipient silence, not adding turns. However, they were also observed to end the suspension of talk especially when the silence exceeded 10 s. Doctors, on their part, resumed talk via *back reference* devices, e.g. restatements of topic or anaphoric forms.

Well aligned with Newman et al.'s work, both in scope and methodology, our study provides an original contribution insofar as it focuses on the more specialized context of oncology. The oncological encounter presents a number of distinct characteristics—some pertaining to the oncologist and some to the patient—which have a bearing on doctor-patient interactional dynamics. Prior research on oncological visits has shown that despite its significantly greater complexity, the cancer diagnostic evaluation is usually carried out by the oncologist within the visit itself [16,17]. Centered on the scrutiny of the histological exam, the diagnostic phase of the visit sees the oncologist also consulting additional documents, reading them, writing notes [18], in other words the range of actions that Newman et al. refer to as "interactions with information" [15]. The demand on the oncologist of this engagement with medical artifacts and reasoning is also attested by the length of the diagnostic assessment, which is the longest phase in the visit [17].

On the patient side the oncology visit is an emotionally charged event, replete with uncertainty at multiple levels. Differently from encounters with GPs, cancer patients are unfamiliar with oncology visits. And this is especially true for our study, which examines *first visits* (see below). Patients thus need to figure out ongoingly what the oncologist is doing and what is expected of them—what to say and when. At the same time patients have their own expectations and apprehensions, notably about the severity of their condition and the prospects for their future, which they anticipate the oncologist to discuss with them during the visit [18–21].

The oncology visit is thus an event within which mutual understanding and coordination of action cannot be assumed as a given, nor as an easy pursuit, but rather as a dynamic process. Our analyses will bring to the surface the incessant interactional work that each and all participants contribute towards securing intersubjectivity. In the discussion section we will unpack the relevance of intersubjectivity as foundational dimension of communication, discussing its vulnerable and yet essential status in oncology visits.

2. Methods

2.1. Setting

Our data collection was carried out in the oncology department of two Italian public hospitals—a medium-size hospital and the teaching hospital of the largest Italian university. The total amount of new patients that refer to both hospitals is about four hundred per year. Overall, 6 doctors, 56 patients and 44 patient's companions (e.g., family members or friends) participated in the study.

The study received approval from the Ethical Committee of both hospitals. Written informed consents were obtained from all participants, i.e. the doctor, the nurse, the patient, individuals who accompanied her (e.g. a family members or a friend), and any other hospital personnel who entered the consultation room during the visit. Names and other references, which might lead to the participant's identification of personal data, were rendered anonymous.

2.2. Data corpus

Our dataset comprises 56 video-recorded oncology visits, 31 collected in the medium-size hospital and 25 in the teaching hospital. While these are all first time encounters with the oncologist, the patients have already received a cancer diagnosis (delivered by a range of other specialists, e.g. surgeon, radiologist, gynecologist) and they often have already undergone a surgical removal of the tumor. The goals of the visit with the oncologist are to assess the severity of the tumor and to formulate a treatment plan (such as chemotherapy or hormone therapy), aimed at attenuating the risk of recurrence. At the end of the visit, oncologist and patient discuss and stipulate a line of action for the patient's longer term well-being and her health care trajectory.

Most patients in our data corpus are women (80 %) who received a breast cancer diagnosis (77 %). Their average age is 55 years. The patients are usually (66 %) accompanied to the visit by a family member or close friend.

Prior work on this data corpus has documented the structural organization of the oncology visits [17], delineating six distinct phases: (1) opening (greetings and small talk), (2) anamnesis (personal data, medical history, current health status), (3) cancer's diagnostic assessment (4) diagnostic summary and treatment recommendations, (5) outline of future actions (e.g., next appointments, exams), (6) closing (greetings). Packaging all these activities, in proper proportion and order, is a practical challenge that the oncologist has to face anew, each and every first visit [18] (see also [22] for an analysis of the interaction order in communication in a cancer clinic).

2.3. Analytic procedures

The visit videorecordings were fully transcribed according to conversation analytic conventions (Appendix). For the present study, we then focused on the third phase of the visit, wherein the oncologist carries out a diagnostic assessment of the cancer. The focus is justified by the fact that it is in this segment of the visit that we have observed shifts away from mutual engagement. We examined the mechanics of these changes in participation format and turn-taking organization—what resources are mobilized to accomplish the shift to mutual disengagement, maintain it, and then move back to joint engagement. Each sequence was identified and examined by two of the co-authors independently, and then discussed collectively by all authors.

3. Results

The presentation of our findings is organized in three subsections. First, we examine the strategies deployed by the oncologists for establishing a space for their own private actions with and in relation to the histological exam. Then, we consider how the individual engagement with documents is sustained—a condition all but static and effortless. Finally, we show how the participants resume co-engaging in talk—the default, unmarked interaction format of the oncology visit.

3.1. Towards establishing a space for private activity (reading and writing of medical reports)

The diagnostic assessment always entails careful examination of medical reports by the oncologist, notably but not solely the histological exam. These documents are brought to the visit by the patient and the doctor did not have access to them prior to the medical encounter. Most frequently the patient keeps hold of the documents until the oncologist asks for them. The oncologist's request then is a first step towards pausing the verbal exchange and transitioning toward private involvement with the medical reports. The request is followed by a shift of gaze from the patient to the documents, accompanied by a formulation that introduces the incipient activity.

A 3-step transition sequence thus emerged from our analysis as ordinary strategy employed by the oncologist toward establishing a space for private activity.

Step One: Request of histological exam and other medical reports

Step Two: Shift gaze toward the documents

Step Three: Framing formulation

Example 1 is an illustration of the deployment of this strategy. The oncologist is finishing up the health history taking. The end of this phase is signalled verbally—the oncologist providing, as sequence closing marker, a positive assessment ("oka::y", line 1) as she writes last bits of information just obtained from the patient onto the medical record. The sequence-closing marker is then followed by a sequence opening marker "listen" (line 2) [23], which sets the shift in motion (Fig. 1):

As the patient completes the pre-sequence [24] declaring her readiness to listen (line 3), the oncologist stops writing, raises her gaze to the patient and proffers a request for medical reports (line 4). The request is indirect and unspecific, asking for "documents relative to these things" but presents no problems in understanding: the patient immediately responds verbally in the positive (line 5) and begins searching for the reports in her purse. The oncologist then provides an account for her request (line 7), which anticipates

((The patient has provided the oncologist with information about a few tests, including biopsy, that she did prior to her surgery; ONC is taking notes. Two other documents are placed on the desk, one in front of the patient and one in front of her friend, both brought by the patient to the visit))

01 ONC ocche::i.
oka::y. *((writing, her gaze on the medical record))*

02 ascolti.=[e::::
listen. =[u::::

03 PAT [mi dica.
[yes. *((looking at the medical record))*

04 ONC ha questa documentazione re[lativa a queste cose?
do you have these documents re[lative to these things?
((stops writing and lift gaze to PAT))

05 PAT [certo.
[sure. *((looks inside her bag))*

06 ONC (occhei)
(okay) *((writing))*

07 così intanto lo guardo.
so that meanwhile I take a look at them.
((releases her pen, takes hold of the mouse and turns toward the computer screen))

08 (7.0) *((during this time, ONC first looks at the computer screen, then she moves a paper from the desk to a shelf behind her; PAT looks onto her purse, her friend piles up together the two documents the patient had placed initially on the desk))*

09 PAT allora. *questa è la prima-
so. *this is the first one-
**((hands document to ONC))*

10 questa è l'ecografia
=this is the ultrasound. **(1)**

(1)

11 PAT fatta a set§tembre dove è uscito fuori il tutto.
done in sep§tember where everything transpired.
((looking again inside her purse))
§ *((ONC takes document in her hand and lifts it, begins reading))*

12 (0.5) *((ONC nods))*

13 questa è la rison^anza,
this is the MRI sc^an,
((taking the scan off the purse and placing it on the desk)) **(2)**

(2)

14 (21.0) *((while ONC copies data from the scan to the medical record PAT takes out of the purse three additional documents, one by one))*

15 FRI °( )°

16 PAT °e: si. (1.0) sto cercando varie cose.°
°uh: yes. (1.0) I'm looking for a few things.°
((putting the purse on the floor))

17 (6.0) *((ONC is copying information onto the medical record; PAT opens the last document she has taken out of the purse and places it on the desk))*

18 FRI °( )° *((to PAT, touching the document on the desk))*

((ONC continues copying, PAT looks at ONC and medical record, back and forth))

Fig. 1. Extract 1 Participants: ONC (oncologist), PAT (patient, female, 46-year-old), FRI (patient's friend).

her activity with the documents: she will take a look at them. Her imminent disengagement from the verbal interaction with the patient is thus both announced and explained. Conversation Analytic research has demonstrated the central role that accounts play in securing mutual intelligibility among interactants and in maintaining social solidarity (e.g. [2,24]). Specifically, accounts have been shown to be produced in relation to dispreferred action sequences, when departures from the expected ordinary unfolding of interaction might otherwise generate misunderstandings or misalignments [24]. In this extract the proffering of an account reveals the oncologist treatment of what is announced as upcoming as both important and delicate.

As soon as the patient hands her the first medical report, i.e. the ultrasound (lines 9 and 10, Picture 1.1), the oncologist lowers her gaze and begins examining the document silently (line 11) and nods (line 12). She keeps her focus on the ultrasound report as the patient makes other medical reports available to her (line 13). It is worth noticing that once the oncologist is fully involved with the ultrasound report, i.e. the first document the patient handed her, the patient sets the additional documents on the desk, at easy reach for the doctor with no need for her to divert gaze or adjust the current axis of involvement. A brief exchange with the friend accompanying the patient to the visit (lines 15 and 16), uttered in low volume, enacts the patient's own separate involvement with documents and signals no intention to interfere with the doctor's ongoing private activity. When all the relevant reports at the patient's possession have been made available to the oncologist, the patient takes a waiting position, remaining silent and shifting back and forth between monitoring the oncologist reading and writing and gazing at the documents near her on the desk.

A further illustration of the doctor's disengagement process into private activity, example 2 is also representative of some slight variations on the transitional sequence. Since the patient had handed the oncologist all relevant documentation in her possession at the beginning of the encounter, the doctor does not need to ask for them when he is ready to examine the documents. The shift in focus towards the medical reports is announced and then accounted for in a way that gives explicit instruction to the patient on how to behave while the oncologist is engaged with the documents (Fig. 2).

The oncologist has just offered the patient a rather elaborate explanation of possible degrees of breast cancer's severity and therapies that best address the different oncological conditions (not included in extract 2). While checking that the patient and her daughter (who is present at the visit) have understood him, the oncologist signals that more will follow (with the "so far", in line 1). Then, being reassured that his explanation was clear, he closes the sequence with a positive assessment ("perfect", line 5). Next, he announces the forthcoming activity, in line 6, with a statement that, including the first person plural ("let's go check"), invites shared participation. The statement is incomplete and does not specify what's the object of scrutiny but the shift in gaze and bodily posture towards the histological exam completes the line of action. Patient and daughter align with the oncologist, by directing their gaze on the exam. In the following seconds, while repositioning and rearranging other documents earlier placed on the desk, both daughter and patient keep their body orientation and gaze toward the oncologist (lines 8–12). Their posture, gaze and conduct are a *display of recipiency*, indexing their readiness to engage with the oncologist in the review of the oncological exam.

Possibly under the pressure of that display of recipiency—which as Heath has pointed out "declares an interest in receiving a response, a response in immediate

((The oncologist has explained to the patient and her daughter that the histological exam—which the patient had brought to the visit and placed on the desk at the beginning of the encounter, and he had not yet seen—will convey key information about the biological behavior of the cancer. Placed on the desk, between PAT and ONC, are the histological exam, two pre-surgery cancer scans, and a folder with abdominal scans))

01 ONC tutto chiaro [fino a qua?
everthing clear [so far? *((looks at DAU))*

02 DAU [si.
[si.

03 PAT si [si=si.
yes [yes=yes.

04 DAU [°a posto.°
[°all right.°

05 ONC per*fetto. (1.0)
per*fect. (1.0)
((ONC takes the histological exam from the pile of documents in front of the patient and places it in front of him, lowering his gaze toward it))* **(1)

(1)

06 ONC andi*amo (.) a guardare.
let's *go (.)check.
**((turns document page and starts reading))*

07 PAT **( )** *((moves the documents left in front of her toward DAU, as to ask to put them away))*

08 (3.0) *((PAT hands folder to DAU; DAU places it in front of herself on the desk))*

09 ONC **mhm. (2)**

(2)

10 (1.0) *((PAT hands scans to DAU))*

11 DAU °(lascia)°
°(leave it)°

12 (1.0) *((PAT takes back again the folder from the desk and moves it back where it was previously placed; DAU holds her gaze toward ONC))*

13 ONC allora. (0.5)
so.(0.5)

14 adesso dovete sta' zitte £zitte=
now you have to be £quiet *((lifting his gaze to DAU; halt hand gesture))*

15 =perchè £de- io devo scri[vere.
=because I £hav- I have to [write. *((starting to write))*

16 DAU [si=si=£prego.
[yes=yes=£please. *((lowering gaze and putting scans in the purse))*

17 PAT [si=sì eh eh
[yes=yes eh eh *((laughing; then turns the folder on the desk toward herself))*

18 ONC sennò mi con£fondo.
otherwise I get con£fused. *((looking at the histological exam, reads and copies onto the medical record))*

19 questa è la parte più importante °di tutte.°
this is the most important part °of all.° *((copying onto the record))*

Fig. 2. Extract 2 Participants: ONC (oncologist), PAT (patient, female, 70-year-old), DAU (patient's daughter).

juxtaposition with the display" [9: 154]—the oncologist reengages in the main intersubjective axis, looking at the patient's daughter to deliver instruction: she and the patient shall be silent while he focuses on the histological exam (lines 14 and 15). Undoubtedly a bold command, the oncologist mitigates it with a smiling voice and an account that justifies the necessity for him to secure a moment of private, uninterrupted focus on the medical report (line 15). The work that he has to do with the histological exam is the "most important" (line 19) and demanding, thus liable to generate confusion (line 18). Even before the delivery of the account, both the patient and her daughter express assent and shift their gaze from the oncologist to the documents they are handling (lines 16 and 17). It is worth noticing, however, that both patient and daughter add to their assent the marker "please", which is typically used to agree politely to a request, thus treating the oncologist directive as a request for permission to disengage from the interaction rather than a command not to interrupt him. Moreover, the patient alignment is somewhat emphatic, with an overt laughter that reveals the exchange as pregnant with emotional significance (likely, a combination of humor and apprehension).

3.2. Maintaining a space for private activity

Just like mutual engagement is enacted and sustained via coordination of turns at talk and non-verbal cues, mutual disengagement requires coordinated action to be sustained through time. In other words, it is not sufficient that the oncologists achieve a suspension of mutual gaze and talk. Their private engagement with the medical reports needs to be sustained moment-by-moment. In our data, the maintenance of private space involved setting in place protective implements, via body gloss or verbal strategies. We borrow from Goffman [8] in labelling these implements as *involvement shields*, though Goffman used the term primarily to refer to actions aimed at minimizing the display of improper situational involvement, such as the use of "newspapers to cover mouths that should not be open in a yawn" [8: 40].

Bodily posture, with torso bent towards the desk and gaze focused on the documents, was a most common involvement shield deployed by the oncologists in our data set. At times such bodily shield was combined with a verbal protective device, i.e. oralized reading and writing. Oralizing acts of reading and writing has been documented by previous research on doctor-patient interaction [15,18,21] as an effective strategy that provides opportunity for the patient to access and follow the doctor's activity as it is carried out, thereby promoting patient's knowledge and understanding of medical practice. During the cancer diagnostic assessment phase, as the following example shall illustrate, reading aloud and oralized writing can simultaneously give patient access to the oncologist analysis of the histological exam and diagnostic reasoning and restrain such access to some extent, by limiting the patient involvement to that of a silent observer, at least during the process of studying the documents (Fig. 3).

After requesting (line 1) and then securing himself the histological exam (line 4), the oncologist turns its first page (line 9) and comments on the lengthiness of the report (line 10). In response to the patient objection that it is the last segment of the report that which is important (line 11)—a display of patient's competence and agency, albeit mitigated by "I think" in line 13—the oncologist points out that he has to read it entirely (line 14). After this formulation of intent comes a brief segment of oralized writing ("esame istologico", line 15) to which then follow 7 s of silent involvement with the report (line 16). The patient aligns with it by keeping herself busy with reordering scans and other

01	ONC	ecco. (.) mi dia l'esame istologico. **okay. (.) can I have the histological exam.**
02	PAT	allora **so** *((opening green folder in front of her on the desk))*
03	(1.0)	*((PAT takes two folded documents out of the folder; ONC bends his torso over the desk toward the documents))*
04	ONC	che è qu*esto immagino. **which is th*is one I believe.** ***((takes a document from those PAT was leafing through))**
05	PAT	si. **yes.**
06	(1.0)	*((ONC places the histological exam on the desk in front of him and looks at it))*
07	(1.5)	*((PAT takes another document from the folder))*
08	PAT	questa è la prima parte.=guardi. **this is the first part.=look.** *((handing the document to ONC))*
09	(1.6)	*((ONC turns the first page of the histological exam))*
10	ONC	madonna quant'è lu:ngo:. **my goodness how lo:ng it is.**
11	PAT	§si però è: (.) è l'ultima parte che conta. **§yes but it's (.) it's the last part that matters**
12		§ *((ONC holds gaze on document))*
13	PAT	°mi sembra.° **°I think.°**
14	ONC	eh si però io me lo devo legge' tutto. **sure but I need to read it all.**
15		.hh allora. *esa:me istologico. **.hh so. *histological exam.** ***((starts copying from exam to record))**
16	(7.0)	*((ONC reads the histological exam; PAT puts back documents in the folder then looks at ONC))*
17	ONC	**°mh.°** *((shaking head slightly and making small waving gesture, while keeping gaze on document))* **(1)**

(1)

18	(1.0)	*((ONC reads; PAT continues to reorder documents previously placed on desk))*
19	ONC	penso che tutto sommato non dovrebbe andare, **I believe that all things considered it shouldn't be,**
20	(0.8)	*((PAT looks at ONC then at histological exam))*
21		dic*eva questo qui? **did you me*an this one?** ***((pointing to histological exam))** **(2)**

(2)

Fig. 3. Extract 3 Participants: ONC (oncologist), PAT (patient, female, 67-year-old).

documents that she had previously taken out of her folder. While keeping his eyes on the documents (lines 16–18), the oncologist produces an interjection (line 17) that recruits the patient's gaze and attention (Picture 3.1). He then proffers an assessment (line 19), which incompleteness and unspecified reference give evidence that it was primarily directed to himself, as part of his private reasoning. The remark, however, is taken by the patient as resuming the speech exchange and she immediately pursues some

22 perché quello è due più che ne so.
why it that two plus I have no clue.

23 ONC si: si. poi le spiego pure quello.
yes: yes. later I'll explain that one too. *((keeping gaze on documents))*

24 (1.0) *((PAT puts hands on cheeks and directs gaze to document ONC is reading))* **(3)**

(3)

25 ONC allora esame istologico.
so histological exam *((moving document closer to himself))*

26 intanto leggiamo tutta la pappardella.
first let's read all the lengthy stuff.

27 (7.0) *((ONC reads under his breath; PAT resumes reordering documents placing one into an envelope))*

28 ONC allora
so *((keeping gaze on document, lowers pen on paper to write))*

29 (1.0) *((PAT continues reordering documents in the envelope without changing gaze direction))*

30 ONC questo è l'ultimo. quello che conta.
this is the last one. that which matters.

31 ci a duttale infiltrante.
c- a ductal infiltrant.

32 (5.0) *((ONC writes, PAT completes placing documents in the envelop and then turns to look at the paper ONC is writing on))*

33 ONC il diametro (.) è-
the diameter (.) is-

34 PAT è piccolino per fortuna.
it's small luckily.

35 ONC buo:na:. *((to PAT while keeping gaze on documents))*
quie:t:.

36 (1.5)

37 ONC diametro centrimetri dove sta […]
diameter centimeters where is it […]

((ONC continues reading aloud and copying from exam to record))

Fig. 3. (Continued)

clarification on numerical values on the histological exam, pointing to the document (lines 21 and 22; Picture 3.2). After providing a rapid and minimal reply, without turning his gaze to the patient, and then announcing a more substantial response as coming shortly (line 23), the oncologist utters a restarts ("allora esame istologico", line 25) and frames again the incipient activity as reading the lengthy histological exam (line 26). He then comments on what he is copying from the exam onto the current medical record (line 30) and reads aloud a brief segment of the exam (lines 31 and 33). These activities, with the reading having been framed in the first person plural as jointly carried out (line 26) and made accessible to the patient via oralizing (lines 31 and 33), yield to a further intervention by the patient, a collaborative completion [25] in line 34. The oncologist, however, is not quite ready to reengage with the patient and invites her to be quiet (line 35) before continuing his activity of oralized copying of information.

Extract 3 thus shows that the oncologist private space needs to be sustained moment-by-moment, and in fact is rather vulnerable to patients' incursions. Making sense of extended stretches of silence or intersubjective disengagement is difficult for the patient, not to mention apprehension triggering (for a discussion of this aspect see section 4). Our analysis reveals that vulnerability of the private space is often related to oralized reading and writing. For the oncologist, reading and writing aloud is closely connected to his scrutiny of the histological exam, which requires exclusive attention and no interruption. For the patient, however, oralized information processing activities are opportunities for asking questions to the doctor or anyway for continuing the speech exchange. In reclaiming exclusive engagement with the documents and suspension of speech exchanges, when such condition is threatened by the patient's queries or comments, the oncologist

((The oncologist is transcribing information from the patient's histological exam onto her medical record.))

01 ONC estrogeni,
estrogens, *((reading aloud information from the patient's histological exam))*.

02 (2.0) *((ONC starts writing, PAT folds the documents into an envelope))*

03 **e §r,**
§*((PAT lifts gaze at ONC, putting the envelope on her lap))*

04 (1.0)

05 più più-
plus plus-

06 (.) *((PAT opens her mouth as to begin to speak , then stops))* **(1)**

(1)

07 più più più:,
§plus plus plu:s,
§*((PAT looks at the record ONC is writing))*

08 PAT .h cosa sono tutti quei più:?
.h what are all those pluses? *((shaking head no, looking at the documents))* **(2)**

(2)

09 ONC e mo glielo spiego.
I'm §going to explain to you
§ *((PAT lifts gaze to ONC))*

10 PAT (ecco.)
(fine.) (3)

(3)

11 PAT eh eh heh *((laughs, while taking more documents from the desk and putting them onto a transparent envelope))*

12 ONC ti £gi erre.
t £g r.

13 (1.0) *((ONC writes))*

14 ONC più più più,
plus plus plus, *((copying))*

15 insomma s*ono buoni questi più più più.
anyway t*hey are g§ood, these plus plus plus
*((lifts gaze toward patient))
§ *((PAT lifts gaze to ONC))*

16 PAT ah. più pi↑ù sono buo:ni.
oh. plus pl↑us are goo:d. *((ironic tone, keeping the gaze on ONC))*

Fig. 4. Extract 4 Participants: ONC (oncologist), PAT (patient, female, 51-year-old), HUS (patient's husband).

often projects resumption of talk and closing of private space as upcoming.

3.3. Closing of the private space and resumption of mutual engagement

The closing of the private space is produced by changes in body orientation followed by resumption of talk. More specifically, gaze contact with the patient is re-established and a summary of the diagnostic assessment is prefaced by a discourse marker—either "dunque" or "allora" (both corresponding to *so* in English) or "insomma" (*in sum* or *well*) (Fig. 4).

In extract 4 we observe the oncologist busily engaged with the medical documents, specifically copying information from the histological exam into the patient medical record. Securing private space for studying the document wasn't effortless in this visit since there was no clarity about what had been carried out on the patient already (fine needle aspiration and/or surgical removal of the tumor) and she had a few questions for the oncologist. While the patient holds a recipiency position, in fact seizes the oncologist attention by raising a hand and opening her mouth (line 6, Picture 4.1), he keeps his gaze on the document and oralizes his writing. Then the patient inserts herself with a question: she queries about the meaning of plus signs (+) that the oncologist has just copied (line 8). Her voice intonation is ascendant and the last word prolonged. She shakes her head and holds her gaze steady towards the oncologist (Picture 4.2), conveying a sense of uneasiness, perhaps disappointment or apprehension for being constrained to silent audience to the doctor's *solo* reading. The oncologist raises his gaze and replies briefly and quite dismissively (line 9) before lowering his gaze to the document and continuing writing. His brief response however projected an explanation as upcoming. As a matter of fact after a few more seconds of oralized writing, the oncologist raises his gaze again, utters the discourse marker "insomma" and provides a first assessment of the information gathered from the histological exam (line 15), before moving on presenting the main characteristics of the patient's cancer.

Here again, as in excerpt 3, the oncologist halts the patient from querying about the meaning of the numerical values he is reading, conveying that a patient's intervention at this moment is temporally inappropriate. Differently from excerpt 3, though, here the patient does not proffer an unambiguous alignment: her response "ecco" (line 10) is closer to the English "fine" than "okay" or "sure." This seems to motivate the oncologist to revise his response, turning to gaze the patient and previewing the reassuring meaning of the numerical values. This turn (line 15), which ends up transitioning participants back to mutual speech engagement, reveals that the oncologist's private space is not only precarious but also threatening with respect to participants' alignment and harmony.

4. Discussion and conclusion

4.1. Discussion

This paper has given attention to moments of the medical encounter previously neglected in doctor-patient interaction studies, i.e. segments when doctors retreats into private engagement with texts. In the oncology visit, such moments occurred when doctors directed their focus on the histological exam and engaged in acts of reading and writing—transcribing and annotating information therein contained onto the patient's medical record.

The histological exam document contains key information—notably the molecular composition of the tumor, its sensitivity to hormones, the proliferation rate of cancer cells—which allows the oncologist to design a treatment plan that responds to the specific characteristics of the disease and the patient. Given its importance and complexity, the diagnostic assessment is more and more frequently carried out prior to the visit and collectively by a healthcare team, called tumor board, which includes oncologists, surgeons, pathologists, and radiologists. In our data the oncologists carried out the diagnostic assessment during the visit and on their own, which made the establishment of mutual disengagement critical to a satisfactory accomplishment of the difficult task.

Mutual disengagement in oncology visit represented a departure from the default intersubjective configuration, which had doctor and patient as main interlocutors, sustaining reciprocal gaze and exchanging turns at talk, primarily in a question and answer format. As marked intersubjective configuration, mutual disengagement required interactional work for its establishment, maintenance and cessation.

We have identified resources, both verbal and nonverbal, deployed by the oncologists to achieve a private space for their own individual involvement with documents. Such resources—notably handling of documents, shifting gaze toward the histological exam, and reframing activity formulations—were generally configured in a 3-step transition sequence. Similarly to the practices that Greatbatch [4] found in doctors handling the competing demands of communicating with patients and writing prescriptions, we also observed that while oncologists sought a private space for their demanding diagnostic task, they generally kept a minimal level of reciprocal engagement with patients, via sparse and brief comments or oralized reading and writing.

Indeed we have found that patients monitored closely and constantly the oncologist activities, mostly aligning with and supporting them effectively: As Greatbatch [4] observed in consultations conducted in medical practice in England, oncology patients oriented to the doctor focus on documents and avoided actions which could elicit their gaze and disrupt their private activity. Specifically, when oncologists initiated a shift out of mutual engagement, patients deployed their own resources for enacting disengagement—or in conversation analytic terms, for *doing being* disengaged [26]. At the same time they maintained availability to be reengaged at any moment, and at times displayed an eagerness to shift back to joint engagement via displays of recipiency.

Our analysis has also shown that when talk and reciprocal engagement were suspended, intersubjective alignment became particularly vulnerable to breakdown. The oncologist momentary displays of joint engagement were at times misunderstood by patients as closings of the private space. Misunderstandings then necessitated repair work [27] for regaining intersubjective alignment with mutual disengagement. Repairs were also necessary when patients brought mutual disengagement to a halt via interjecting talk, notably clarification questions, into the oncologist's silent involvement with documents. Unarguably, the oncology visit was an encounter filled with apprehension for the patient [28,29] for what she knew already—i.e. that she was to receive a cancer diagnosis and treatment recommendation—and for what she did not yet know—i.e. the severity of the cancer and the prospects for recovery. When talk and reciprocal engagement were suspended, we have seen patients display signs of apprehension—e.g. changes in posture, manipulation of documents. These actions were visible to the oncologist, though it was not always clear if they were noticed. When the oncologist did, these signs were often responded with a brief comment or a stretch of oralized reading or writing, supplying information or anticipating that information will be upcoming. They thus were treated interactionally as displays of recipiency and psycho-emotionally as signs of patient's distress.

4.2. Practice implications

Intersubjective alignment in oncology visits requires incessant reciprocal calibration among participants. Suspension of mutual engagement has emerged as a delicate collaborative process, in fact one also difficult to sustain. In line with Newman et al.'s study [15], our analysis has revealed vulnerability in intersubjective alignment, especially when mutual disengagement extended in time. When bystanders to the oncologist's involvement with documents, patients have more limited resources to understand what's going on. Uncertainty and their own sense of vulnerability increase.

As much as it is essential to the oncologist work, mutual disengagement threatens the successful unfolding of the medical encounter. We thus suggest that more conscious handling of the oncologist's private space can be beneficial to the patient, and a favorable outcome of the visit more broadly. On the basis of what we observed in our data, we envision a number of strategies that the oncologist can deploy to reduce the threats to intersubjective alignment during mutual disengagement: 1) make the patient cognizant of the need and demand of studying the histological exam towards formulating the cancer diagnosis; 2) provide a clear formulation of what's upcoming, with an approximate indication of the time needed to carry out the task; 3) sustain a level of minimal reciprocal involvement; 4) monitor patient's signs of apprehension and display sensible responsiveness to them.

4.3. Conclusion

Despite the hierarchical and regimented structure of specialized medical encounters, the oncology visit is a dynamic interactional undertaking, replete with moment-by-moment shifts in and negotiations of participation. The presence and vulnerability of shifts away from mutual engagement in the oncology visits exposes and complicates ideas on power dynamics and asymmetry in medical encounters [30,31]. In line with preceding conversation analytic work on doctor-patient interaction [3,5,14], our study's findings eschew a characterization of the oncologist as solo arbiter of the unfolding of the interaction. While the oncologist acts as chief orchestrator of the medical encounter, an alignment with the patient is key to the felicitous accomplishment of the visit. Thus, the oncologist responsibility is not only to carry out clinical tasks but also to co-construct with the patient an experience of interactional attunement and mutual understanding.

CRediT authorship contribution statement

Laura Sterponi: Conceptualization, Methodology, Formal analysis, Writing - original draft, Writing - review & editing. **Cristina Zucchermaglio:** Conceptualization, Resources, Investigation, Supervision, Methodology, Formal analysis, Writing - review & editing. **Valentina Fantasia:** Conceptualization, Methodology, Formal analysis, Writing - original draft, Writing - review & editing. **Marilena Fatigante:** Conceptualization, Methodology, Investigation, Formal analysis, Writing - original draft, Writing - review & editing. **Francesca Alby:** Conceptualization, Methodology, Investigation, Formal analysis, Writing - review & editing.

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Appendix

Transcription Conventions

.	The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence.
?	The question mark indicates rising intonation, not necessarily a question.
,	The comma indicates "continuing" intonation, not necessarily a clause boundary.
:::	Colons indicate stretching of the preceding sound, proportional to the number of colons.
–	A hyphen after a word or a part of a word indicates a cut-off or self interruption.
word	Underlining indicates stress or emphasis on the underlined item.
° °	The degree signs indicate the segments of talk that are markedly quiet or soft.
><	The combination of "more than" and "less than" symbols indicates that the talk between them is compressed or rushed.
=	Equal sign indicate no break or delay between the words thereby connected.
(())	Double parentheses enclose descriptions of conduct.
(word)	Words or speech segments in parentheses indicate uncertainty on the transcriber's part.
()	Empty parentheses indicate that something is being said but it remains unintelligible.
(1.2)	Numbers in parentheses indicate silence in tenths of a second.
(.)	A dot in parentheses indicated a "micropause", hearable but not readily measurable; ordinarily less than 2/10 of a second.
[	Separate left square brackets, one above the other on two successive lines with utterances by different speakers indicates a point of overlap onset.
hhh	Letter "h" indicates hearable aspiration.
£	Smiling voice.
*	Annotation of multimodal features (e.g. gaze) of the speaker, co-occurring with the speaker's words.
§	Annotation of multimodal features (e.g. gaze) of co-participants, co-occurring with the speaker's words.

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