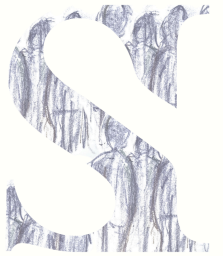

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Video-Based Studies of Human Sociality

Therapist and patient accountability through tactility and sensation in medical massage sessions

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Abstract

This paper looks at the issue of therapists' and participants' accountability regarding a perceived problem in routine medical massage sessions. Specifically, it shows how therapists and patients communicate their tactile perception and sensation of the problem by negotiating their accountability for the current state of the treated body part. Drawing on video-recorded data of 12 routine medical massage sessions at home and five sessions at a clinic, this paper demonstrates that there is a normative order with regard to the participants' accountability for the patients' problems. In routine sessions, patients presumably have a problem (e.g., body stiffness or tension) that needs to be treated. The physical therapists' accountability for the problem is usually displayed via direct access to the treated body part for their attentiveness to as well as validation of the patient's claimed problem, making the medical treatment relevant. The patients are also accountable for their own problems as they are expected to have the primary right and obligation to look after their own health. Through multimodal and sensorial practices, therapists balance their medical and professional authority with their patients'

concerns, for which the patients claimed to have first-hand experience and independent access to the problem. The data is in Japanese.

Keywords: Physical therapy, accountability, tactile perception, proprioception, knowledge, experience, self-care

1. Introduction

This paper examines ways in which therapists and patients communicate their tactile perception and sensations received through one's own body of a problem (i.e., aches and pains in particular body parts) by negotiating the rights and obligations for the state of the treated body part in routine medical massage sessions. During the sessions, therapists engage in several forms of communication with patients and/or co-present family members. Frequently, there is procedural talk informing the patient of what the physical therapist will do next or counting the physical movements when stretching the patient's arms or legs. In each case, the therapist's talk, physical manipulation of the patient's body, and the patient's proprioceptive and kinesthetic perceptions are important resources to construct a specific action accomplished by therapists (Nishizaka, 2016). Physical therapists frequently communicate their tactile perception of the treated patients' body parts. It should be noted that for the therapists, touch is the primary sensorial perception on which they build their understanding of a patient's problem and use it to help alleviate the problem. Because of these features, the therapist's touching of a patient's body is omnirelevant, as the main activity consists of massaging the patient's body. During my observations of several sessions in Japanese, I noticed that therapists do not randomly talk about their tactile perception, rather, they talk at interactionally relevant moments. Moreover, what they say is designed to be heard as referring to the currently treated and relevant body part.

The observation that these reports based on the therapist's tactile perceptions are provided "online"[i] (i.e., demonstrably through talk and touch) has procedural consequentiality (Schegloff, 1991) in this specific context. In routine massage sessions, on the one hand, therapists are normatively accountable for addressing patients' chronic problems. By basing their reports on their tactile perceptions, they can demonstrate their perspective towards the patients' perceived problems. Similar to C. Goodwin's (1997) claim concerning professional vision, therapists' tactile observations can emerge as the object of relevant knowledge for the accountability for their own actions of acknowledging, confirming, and validating the patient's complaints (i.e., particular reasons for

receiving medical treatment; see Robinson, 2006). On the other hand, the patients normally have a legitimate medical reason for their therapeutic sessions, but they are not completely freed from institutional norms. The present empirical exploration suggests that patients are also accountable for their own problems so that therapists can provide the appropriate treatment for a positive outcome to the problem (cf. Halkowski, 2006). It also suggests that there is a normative order adhered to by the participants in terms of the patient's and the therapist's accountability (i.e., rights and obligations) (cf. McArthur, 2018, 2019; Peräkylä, 2006). I will explore in what ways therapists' tactile observation as a relevant object of knowledge (C. Goodwin, 1997) and patients' sensations can emerge for addressing their accountability for the problems in this particular area of "intercorporeality" (Merleau-Ponty, 1968). Throughout this paper, the focus is on the participants' accountability in terms of their "moral responsibility" (i.e., being a moral/reasonable patient/therapist) for producing and responding to the concerted action based on the relevance of a specific activity (Robinson, 2016) as well as their rights and obligations for their perceptions and sensations. Hence, I will show that both therapists and patients are accountable for their own deeds and thus when their expected actions in accordance with relevance rules are jeopardized, they are morally held accountable. In the following, I will firstly review the literature and introduce the database used for this study. I will then explain the organization of the above-mentioned tactile perceptions by physical therapists as well as the patient's sensations of problems based on the participants' orientation to each other's accountability for the problems.

2. Background to the study

The notion of intercorporeality points to a very foundational and crucial aspect of being in the world; that is, our compresence and co-perception of our bodies and others' bodies (Meyer, Streeck, & Jordan, 2017). The idea of the human body's capacity to have double sensations (Merleau-Ponty, 1962, p. 106) extends to the intersubjective understanding between one's body and another's body. In this way, in ordinary interaction, as Meyer and his colleagues (2017) argue,

intercorporeal interaction is constituted by a double embodiment, as it creates an occasion on which "object and subject are able to temporarily merge, since the body is both subject and object" (p. xx). In reality, intercorporeality can be realized by a very specific action for practical purposes. For example, Cekaite and Kvist Holm (2017), Goodwin (2017), and Goodwin and Cekaite (2018) have described the mundane practices of how the intercorporeality of one's experience through touching others constitutes the engagement of care for, and intimacy with, others in intimate interactions. For instance, an adult (i.e., parent or preschool teacher) may comfort a crying child by holding or hugging when his or her body part is injured, as touching another emotionally and physically attends to affectivity with care for the recipient (Cekaite & Kvist Holm, 2017; Goodwin, 2017). Similarly, Meyer (2017) has discussed the particular ways in which members of the Wolof culture deploy a tactile turn-taking technique as a replacement for gaze, since looking at others is avoided as it is viewed as aggressive staring.

In terms of the touch used by professionals in conducting expert work, Nishizaka's (2007, 2017, 2018, this issue) work is the most relevant to the current analysis. For instance, in interactions between midwives and pregnant women, he observes how the pregnant woman reacts and accepts the exact location of a focal object given via the midwife's instruction of what to "see" during the vaginal palpation through a specific referential practice (Nishizaka, 2007). Furthermore, by analyzing the syntactic construction of a physical therapist's procedural utterances (e.g., "please raise your arms"), Nishizaka (2017) demonstrated that the physical therapist's turn is syntactically designed to be sensitive to the placement of the turn in relation to the physical manipulation of the patient's body, which can elaborate on the meaning of a current turn. It has been shown that the very fact of one being the object of the other's touch is an accountable phenomenon as the intersubjectivity of participants is "embedded and experienced in concrete, intercorporeal action" (Meyer et al., 2017, p. xviii) occurring within this kind of professional work. Furthermore, in his recent analyses, Nishizaka (2018; 2019) has demonstrated how the participants make a distinction between knowledge and perception, such as the visual, auditory, and tactile, when constructing a very specific action. The current analysis will

contribute to this body of knowledge on how tactility in the intercorporeal relationship is realized in the course of a specific action by examining the mundane activity of one being the object of another's professional touch for medical treatment.

3. Data and the context of home medical massage

The data used for this study consists of 12 videotaped home medical massage treatment sessions (12 patients) and five sessions recorded at a medical clinic (5 patients) in Japan, providing an approximate total of 8.5 hours of data. The former sessions were offered by a private company, and the latter by a private hospital. All 12 physical therapists (both male and female) were between 20 and 40 years of age. Patients' ages ranged from 50s to 90s. Each session lasted for about 30 minutes. The home medical therapists were dispatched to provide services related to home care such as massage and acupuncture for patients whose activities of daily living (ADL) were fairly reduced. Most of the patients were elderly and suffering from chronic pain or paralysis due to a past injury or a stroke. Especially those patients using the home care service had more severe problems that prevented them from visiting the hospital on their own. All the participants in the study provided written consent prior to the recordings. In the entire data set, 24 tactile observations from the home medical service context and another 21 from clinic sessions described the physical therapists' tactile perceptions, all of which were identified and transcribed according to transcript conventions developed by Jefferson (2004) and Mondada (2019). In what follows, all cases will demonstrate that the physical therapist's tactile perception is treated as a "professional touch" which can be utilized as a resource to confirm the problem in the patient's body.

4. Analysis

As Nishizaka (2011, 2016) has shown, one's touching of another is made accountable for the touched co-participant within a practical activity such as referencing the object in a distinctive way. In the current corpus, the public announcement of the therapist's tactile perception seems to have a normative relationship between the therapist's conduct and the patient's orientation their current concerns. In routine medical sessions, it is expected that a patient has a physical problem such as stiffness or pain. Thus, the therapist's description of the problematic body part can work not only to inform patients but also to demonstrate and confirm the existence of a patient's problem, thereby validating their claim by making the medical treatment relevant (Heritage & Robinson, 2006). In what follows, I will explain the practices through which physical therapists describe their tactile perceptions while touching as a method of attending to the patient's physical condition for the sake of providing proper treatment and 'educating' the patients with knowledge about their physical condition by negotiating the rights and obligations for the problem with patients.

4.1 Tactile confirmation of a patient's problem: Therapist's accountability

Across different sessions, the physical therapists use their tactile perception to acknowledge and confirm that there is a detectable problem in the patient's body. A typical sequential environment for this is when the patients complain that they have some problem at a particular place of their body. The first excerpt is a case in point. The therapist is working on the patient's right side. Prior to this segment, the therapist and the patient have been negotiating the location of the problematic part. Right before this segment, the search for a specific location of a problem is conducted and the patient just confirmed it (lines 1 and 2).

(1) [HM8; 10:11] Home medical massage, Female patient (50s)

```
01  MAS:     mimi no ushiro?
             ear  GEN back
     mas     >>massaging the pat's neck-->
                  In back of your ear?
02  PAT:     hai.
             Yes.
03  MAS: →   .hhh tashikani %kata:i %*desu yo:ne.
                  indeed    stiff    COP  P
                  Indeed, it's stiff, right.
     mas                  %.......%stretches his upper body and -->
                                   leans forward and keeps massaging
                                     *fig. 1
04           (0.2)
05  MAS:→    .hhh 'chira:↓ne (0.8) chot,° .hhhhh hh tch!
                   this  P         INJ
                This side, (0.8) okay,
06           (0.2)
07  PAT:     koko isshuukan gurai de #ma::ta itaku natte kichatte#
             this  one.week about in again   hurt  become come
             It started hurting again this past week.
08  MAS:     soo desu↓ka.% .hh %↑hantai gawa wa?
             So COP  Q          other side  TOP
             I see.            How about the other side?
     mas                %......%starts massaging lower neck-->
09           (2.0)
```

Fig. 1

When the problematic location is confirmed by the patient (line 2), the therapist's tactile examination of the problem is *occasioned*. As it can take some time to touch and examine the patient's body part after knowing there is a physical problem in the current area, the therapist first takes an in-breath that allows him time to examine the problematic part (line 3). Following this in-breath and massage of the back of the patient's ear, the therapist reports his tactile perception confirming the existence of the patient's problem (line 3: "Indeed, it's stiff, right"). This report has the following six notable features. Firstly, it lacks an overt referent in Japanese; thereby, it is designed to be heard as referring to the currently massaged body part (i.e., behind the ear). Secondly, it conveys the therapist's formulation of the problem, which is a tactile assessment term, "stiff," based on his direct contact with this part. Thirdly, by saying *tashikani* ("indeed"), the therapist is confirming the problem the patient mentioned prior to this moment.

Fourthly, the assessment term (*katai* 'stiff') is constructed with the final particle *yone*, which indexes the speaker's independent access to and epistemic independence of the referent (Hayano, 2017). Fifthly, by referring to the massaging part with a deictic term ("this side") (line 5), he demonstrates that he has 'located' the problematic part. Finally, this confirmation is positioned after the question-answer sequence regarding the location of the problem (not shown in the transcript). By verbalizing his tactile observation from his own perspective as an authority, the therapist's examination of the problem is produced as his obligation to do so rather than 'diagnosing' its symptoms. As the therapist adjusts his body posture to massage the part behind the patient's ear (line 3, Figure 1), his confirmation of the patient's complaint further validates the patient's sensation of the problem. It is after the problem has been validated that the patient further accounts for how she has been monitoring the development of the problem (line 7). Thus, the patient also demonstrates that she is accountable for her own problem (i.e., doing being a good patient). In this excerpt, the therapist displays his professional accountability for validating the patient's complaint through direct touch, which allows the patient to further demonstrate her accountability to take care of the problem.

With similar orientation to the effect of tactile perception by the therapist, in Excerpt (2), the report of tactile observation (i.e., stiffness) is also used to demonstrably validate the patient's complaint. At the beginning of the session, the patient complained of chronic pain in both her arms. Prior to the segment, the therapist started massaging her left lower arm and commented on the stiffness. The patient then explained how she felt pain in her lower right arm, which results in a direct examination by the therapist. Indeed, the therapist starts to demonstrate the location of the problem (line 1) and receives confirmation by the patient (line 2) after which the patient states her sensation of the problem.

(2) [PhTh1_1][3:29] Mid-sized hospital, Female patient

```
01  MAS:    demo yappa, %kono hen: toka ne::?%
             but  as.expected this area etc P
             But, as we expected, around here?
    mas      >>massaging %press her arm several times with his thumb%
             pat's left arm
02  PAT:    %i::tai yo?
             painful P
             It's painful, you know?
    mas      %massaging left lower arm with his right hand
             going up and down                          -->
03  MAS:    i:tai mon ne?=
             painful thing P
             It's painful.
04  PAT:    =u::n.
             ITJ
             Yeah.
05           (0.2)
06  MAS:→   katai no ga:, wakaru yo,* kore.
             stiff  NML NOM tell P   this
             The stiffness, I can tell, this one
                                    *fig. 2
07  PAT:    u::n.
             ITJ
             Yeah.
08  MAS:→   kori kori shite[masu kara. u::n.
             ONP       do:TE:POL because ITJ
             Because it's kori kori (onomatopoetic expression for
             stiffness), yeah.
09  PAT:                    [ °u:::n.°
                              ITJ
                              Yeah.
```

Fig. 2

After emphatically responding to the patient's confirmation (line 3), the therapist further demonstrates his tactile perception of the problem (lines 6 and 8). Similar to Excerpt 1, this observation confirms the patient's reported existence of a problem in a way that the therapist can independently perceive. More particularly, touching the part of the patient's left lower arm (Figure 3), he articulates that he indeed perceives (*wakaru* 'I can tell') the stiffness (*katai* 'stiff') by formulating his tactile perception (i.e., stiffness is available though tactility) and claiming to have the epistemic primacy (i.e., marked by the final particle *yo*) (Hayano, 2011) as a basis for his emphatic response. He does this demonstrably by specifically

locating the problematic part with a deictic term *kore* ('this one') and pointing by pressing on it. He also accounts for his understanding by specifying the type of stiffness with an onomatopoetic expression in Japanese (*kori kori*)[ii] which is only available via direct touch. Where the patient has made a complaint about the problem as her subjective experience, such a demonstrable way of showing the therapist's understanding and perception works as a display of not only emphathy but also accountability for the patient's problem which he can independently perceive and is also obliged to attend to. In this way, the therapist treats the patient's complaint as a valid claim. In both excerpts, the therapist's orientation to providing 'proper' treatment for the patient's claimed problems has been observed.

4.2. Locating and detecting a new problem: Jeopardizing the patient's autonomic care

As stated above, therapists use their tactile perception to validate their patients' complaints through which they demonstrate their accountability for the problem treatment. Even though, in Excerpts 1 and 2, both patients presented their known problem, this is not always the case. At times, patients may not be aware of the problems they have, which is treated as accountable by the participants (i.e., as a *failure* to register by the patient). Excerpts 3 to 5 illustrate such cases. Excerpt 3 comes from the same patient as Excerpt 1, 15 minutes into the session. Prior to this segment, the patient complained of neck and shoulder pain on the right side of her body (she has paralysis on the left). As we join their interaction, the therapist first announces the procedure of massaging the patient's left leg (line 1) and then massages the part for about three seconds (line 2). Subsequently, he reports his tactile observation (lines 3 and 5) while massaging the patient's left toes. Similar to the first two cases, the therapist's report is designed to be heard as being based on his direct access to the referent.

(3) HM8 [15:14] Home medical massage, Female Patient (50s)

```
01    MAS:    *'da  hidari no  ashi mima::s' (0.2)*°'ssho↓::°
              then left   GEN leg  examine:POL       INT
      mas     *puts a cloth on the left leg    -->*massages the left leg
                                                    leg vertically-->
              Then, let me look at your left leg. (0.2) Okay.
02            (3.0)
03    MAS: →  *ma demo* *sotogawa    wa  sugoi   des'    ne. °°%+*yappa°°
              INJ  but  lateral.side TOP intense COP:POL PP  as.expected
              Well, but the external side is intense, as we expected.
                         *fig. 3
      mas     *pats PAT's upper left thigh*
      mas               *grabs the cloth and covers the toes   *grabs the
                                                                left toes
      gaze                                                    +glances
                                                                at PAT
      pat                                                       %nods
04            *(1.2)
      mas     *grabs left toes with both hands; gaze middle distance-->
05    MAS: →  kana↓ri: .hh°hattemasu,°°°'isho.°°
              fairly      tense:POL      ITJ
              It's fairly tense.      O.K.
06            (14.0) ((MAS keeps massaging the PAT's left toes.))
```

Fig. 3

In the therapist's report regarding the patient's left leg (line 3), the turn design indicates that the therapist treats what is detected by him as a fact that he can independently observe without it having been made relevant by the patient's complaint. This observation is introduced with a preface *ma*[iii] ('well') and a conjunction *demo* ('but') to show that he is establishing a contrast (Mori, 1999) with the patient's complaint that did not reference pain in her left side. In addition, the therapist's use of the contrastive marker *wa* referring to the massaging part

indicates that the perceived problem is especially relevant as compared to the patient's non-problematic part (i.e., the inside of her left leg). Although the patient has paralysis on the left (i.e., does not have sensations on the left part of her body), the therapist presents the observation as accessible to and sharable with the patient by using the final particle *ne* (Hayano, 2016, 2017). Moreover, the *sotto voce* increment *yappa* 'as expected' indicates that the therapist has expected the problem he now encounters. He first conveys his observation ("intense") and monitors the patient's reaction. The patient nods when the therapist's report is possibly complete (after the particle *ne*) and displays her affiliative stance; the patient thus acknowledges the therapist's observation (Stivers, 2008). The therapist then further elaborates on the first assessment with a more specific tactile observation (line 5) and continues massaging. This two-step observation of the problem in the paralyzed area is thus constructed to inform the patient by accounting for what kind of problem the therapist independently perceives. Thus, the fact that the therapist's observation is conveyed without the patient's sensation confirms that the therapists are accountable for perceiving and treating these problems.

It is not only the therapists but also the patients who are accountable for awareness and knowledge of own problems. In Excerpt 4-a, the patient has reported a pain in his right shoulder blade when the therapist asks him to review his physical condition prior to the session. After he begins massaging both sides of the patient's upper back (line 1), the therapist offers his candidate understanding of the patient's left side being not especially problematic as the patient did not mention his left shoulder (line 2) (Pomerantz, 1988). However, he soon qualifies his question as relative to the patient's more problematic right side (lines 2 and 3). In this way, the therapist displays his orientation to the patient's right to his own sensation by presenting it to be confirmed by the patient. Since the expected confirmation does not arrive subsequently (lines 4 and 5), the therapist starts to point out that he can perceive the problem in the area by referring to the problematic part through direct touch and a deictic term (line 7). This is received as news by the patient in line 8. The patient in fact formulates the receipt of the news as a candidate understanding of possible problem

detection and by doing so he shows that he is accountable for the perceived problem. In this way, the therapist's demonstration of locating the new problem makes the patient accountable for the detected problem. The therapist confirms it with a mitigated epistemic claim of the problem by which he displays his orientation to the discrepancy of problem detection between them (the laughter also indicates this problematic aspect) (lines 9 and 10).

(4-a) [PhTh_5] [2:26] Mid-sized hospital, Male patient

01 *(6.0)
mas *massaging upper back with both hands going back and forth-->
02 MAS: *hidari wa:: tokuni::*(0.2)*kanji nai ssu↓ka.<ano::mi:gi hodo.*
left TOP especially feel NEG COP Q that right as.much.
You don't feel (0.2) anything special on your left side?
Not as much
03 (.) *de wa nai d'su*?
COP TOP NEG COP
(.) as on the right.
04 (0.5)
05 PAT: *(zutto) ne:::*[( )
all.the.way PP
(All the way) you know.
06 MAS: [>*do' 'ssu ka.*<
how COP Q
How is it?
07 MAS:→ *sukoshi, *koko ni*,=
a.little here at
A little bit, here
mas -->*holds and presses a part with his right thumb-->
*fig. 4
08 PAT: =*kotte* [*masu*?
stiff COP
Is it stiff?
09 MAS:→ [*¥*chotto kinin(h)aru no g(h)a ar(h)u no wa,*
a.little.bit worry GEN NOM exist NML TOP
There's a little bit of something
mas -->*massages back and forth again-->
10 MAS: *ar(h)u n 'su ga::,*¥
exist SE COP but
to worry about but
11 PAT: *a:: sore wa* [*it-*
ITJ that TOP
Oh, that must be
12 MAS: [*aa:*
ITJ

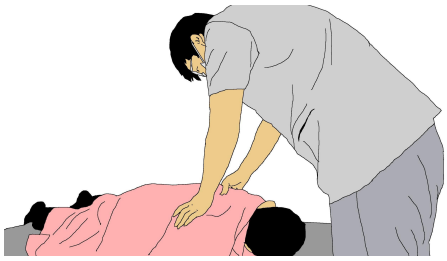
Fig. 4

The patient then accounts for why he did not notice the problem (Heritage, 1988) as “that” can be caused by the exercise he is doing (lines 11, 13, 15). By doing so, he confirms no sensation of the problem but conveys that he has been taking good care of his health. This has met the therapist’s open repair initiator and the laughter indicates trouble in accepting the patient’s account, a discrepancy between their perceptions (line 16). Thus, in the absence of the patient’s expected sensation, both participants show their orientation to the patient’s accountability for the problem. That is, through a two-step and mitigated construction of his tactile observation, the therapist tries to elicit the patient’s independent assessment of the problem whose absence and failure is, for the patient, accounted for.

In the continuation of the above interaction, the patient further demonstrates no sensation of the problem by requesting confirmation of its existence from the therapist (not shown in the transcript). In Excerpt 4-b, the therapist demonstrably confirms it by pressing the problematic part with his right thumb (lines 23 and 26). During the therapist’s demonstrated confirmation, the patient claims that he independently perceives it (line 24). When the therapist reduces the degree of seriousness (lines 28 and 30) by comparing it with the more problematic part (i.e., contrastive marker *wa* in line 30), the patient accepts the therapist’s observation and further confirms the problem only in relation to the right side, which he is aware of (line 31).

(4-b) [PhTh_5] [2:16] Male (60s) [cont'd]

((5 lines omitted))

23 MAS: *aa: hidar<*hidari? hidari ko-* [**kore 'ssu ne. kore.*
ITJ left left left this COP PP this one
Oh, the left- left- left? This one, you know. This one.
mas >>--,,,,,,*pressing the left shoulder blade with his both thumbs
mas *presses a part with his right thumb
24 PAT: [(*nanka aru ne*)
There's something.
25 (0.5)
26 MAS:→ *koko ni ikkasho aru n de:::*
here in one.place exist SE COP
Here's one place so
27 (2.0)
28 MAS:→ *demo soko made de wa *nai 'ssu ne, kocchi.*
but there till COP TOP NEG COP PP this.one
mas ,,,,,,*presses left shoulder blade with his left hand-->>
But not as much as (the other part), this one.
29 (0.2)
30 MAS:→ *hidari no hoo wa,*
left GEN direction TOP
The left part is.
31 PAT: *n:::: mi::gi hodo ja nai* [*'ssu ne:::*
ITJ right as.much COP NEG COP PP
Yeah. Not as much as the right side, you know?
32 MAS: [*migi hodo ja nai 'ssu ne?*
right as.much COP NEG COP PP
Not as much as the right?
33 MAS: *wakarima*[*shi-*
understand
Got it-
34 PAT: [*demo, warito yappari::*
but fairly as.expected
But, fairly expected,
35 MAS: *it(h)a:::i* .hhh

In line 34, the patient starts demonstrating his sensation by revising his prior claim with the contrastive marker *demo* (“but”) and confirms his sensation with more certainty expressed by *warito* (“fairly”) and *yappari* (“as expected”). As soon as the therapist provides his candidate understanding of the patient’s projected sensation (line 35), the patient can confirm it as they both have access to it on their own (the final particle *ne* in line 36; Hayano, 2017). Then, the therapist starts to account for the problem after line 37. In this account, he explains that the problem can be connected to the other problem the patient initially complained of (not all of the interaction shown in the transcript).

Overall, in this lengthy exchange (Excerpts 4-a and 4-b), at first, the patient claims that he did not feel the problem on his own. As the therapist’s massaging and his observation of the problem continue, the patient feels it at last. When the expected sensation is absent from the patient, the therapist gives an explicit ‘instruction’ of how the problem is perceivable in order to demonstrate how the patient can monitor his or her condition independently, thereby treating the patient’s failure to register the problem as accountable. This example clearly indicates that while therapists are accountable for the perceived problems of patients, the patients’ sensations of them are also made accountable as well.

Finally, Excerpt 5 also illustrates how patients (and their family members) are accountable for their own problems. Again from a home visit session, a female patient in her 90s is receiving her regular massage. The daughter of the patient is also present. Contrary to the previous cases, in this excerpt the therapist conveys her tactile observation to the patient’s daughter that there is an improvement in a swelling of the patient’s left foot (lines 2 and 3). Akin to Excerpts 3 and 4, the therapist’s tactile observation (line 2) is stated while massaging the referent: the patient’s left toes (Figure 5); thus, the statement is presented as based on the therapist’s examination of the focal part and as independently accessible by the recipient (i.e., as marked by *ne*).

(5) HM2 [04:27] Home medical massage, Female patient (90s)

```
01          (1.2)(0.8)
    mas     >>massaging the left toes-->>
02  MAS: →  %↑↑ichiba:n +hidoi↓toki to kuraberu↓to:%mukumi
               No.1     bad  when with compare if  swollenness
    m gaze  %DAU--------------------,,,,,,,,,,,,%PAT--->
    dau                 +looks at MAS                -->
            Compared to the worst time, the swelling is
03          chot↓to mashi desu ne.*
            a.little.bit better COP P
            a bit better.
                                *fig. 5
04  DAU:⇒   ps! soo ↓desu ka[↑:
                   so   COP  Q
            Is that so?
05  MAS:                     [*u::↓n
                             "Yeah."
    mas                       *nods
06          (.)
07  DAU:⇒   migi no hoo ga↓%daibu↓↓#ne::#↑mukunde↓ru n [des ne?
            right GEN side NOM fairly P  swelling    SE COP P
            The right (foot) has a lot of swollenness, you know?
    m gaze  -------,,,,,,,,%toes------------------------------>
08  MAS:                                            [aa:: soo↓ °desu↓↓ka.°=
                                                     Oh, is that so?
09  DAU: ⇒  =ee. %↑hidari wa chot↓tto ne:: ii mita↓i hh
            INJ     left  TOP little.bit P  good seem
            Yeah, as for the left foot, it seems a bit fine.
    m gaze  ,,,,,%PAT---------------------------------->
10          (1.6)
```

Fig. 5

The daughter receives the statement of the swollenness as something new as indicated by her gaze towards the therapist, talk, and accompanying prosody (line 4) but soon brings up "another" problematic part in relation to the improvement: foot swelling in the right foot (line 7), contrasting this with the improved left foot (line 9). At this point, the therapist had not worked on the patient's right leg. Thus, in the face of a lack of awareness of the improvement, the daughter claims how she has been closely monitoring the condition of the patient. The daughter's lack of awareness is treated as a failure to register the patient's improvement, which can jeopardize the patient's desire for, and autonomy with respect to, better outcomes.

5. Discussion

Routine medical massage sessions are organized around the assumption that patients have some kind of problem, such as stiffness and pain. Because of this organization, on the one hand, therapists are held accountable for confirming, acknowledging, and stating the claimed problem via their independent tactile perception ("perception-based action" Nishizaka 2018, 2019), making the medical treatment relevant and validating their treatment for medical purposes. On the other hand, patients and their family members are also accountable for their own problems. In this section, I discuss the normative orientation of the two parties' accountability in this setting regarding the treatment of the physical problems.

First and foremost, as it has been argued for visual perception by C. Goodwin (1997) and Nishizaka (2018), tactile perception is also "perspectival" in that how perception is *formulated* by the speaker depends on the local context and contingent action, and thus touching is "the relevant object of knowledge" (p. 607, C. Goodwin, 1997). Based on this conceptualization, the tactile observations produced as professionally and institutionally relevant assessments have their own accountability for the goal of treating the patient's problems properly. On the one hand, when they are produced in response to the patient's complaint, they can validate that the patient has a 'proper' understanding and thus is attending to his or her problems appropriately (Ex. 1 and 2). On the other hand, even when the patients are not aware of their own problems, the therapists are accountable for communicating their tactile observations due to their responsibility for a favorable outcome.

However, there seems to be a normative orientation on the part of the patients to *know* the problems *before* being informed by the therapist as the patients are supposed to take good care of their own problems (cf. Halkowski, 2006). This orientation of the participants becomes visible when the patients fail to notice and register the problems, which is made relevant by the therapist's observation, (e.g., Ex. 4 and 5) (Heritage, 1988). In the patients' accounts, they

claim that they have been monitoring other problems or claim that they have been taking good care of themselves, instead of contesting and rejecting the therapist's demonstrated tactile observation.[iv] Thus, the self-care of the problem by the patients is realized initially in a routine context; while otherwise the therapists are also accountable for communicating the detected problems, which realizes secondarily.

6. Conclusion

This paper has offered a description of an intercorporeal phenomena between physical therapists and their patients that is realized through the therapists' observations based on their haptic evaluations of patients' problems while touching and working on the focal body parts. It has specifically demonstrated that there is a normative orientation on the part of the participants of the accountability for the perceived problems by both the therapists and the patients. On one hand, the patients are accountable for their own physical conditions and management of their health initially due to the sensation of the problem. On the other hand, the therapists are accountable for the treatment of the patients' problems only available through their tactile perception. As patients are treated as having primary and privileged access to their own bodily sensations, therapists have only secondary (although expert) access to the patient's body through their direct touch; therefore, the problem is particularly accountable when the therapist comes upon something the patient did not complain of. Hence, behind the ordered accountability are two normative issues: the patient's need/desire for validation of complaints from the therapist, and also the patient's obligation to report problems and difficulties experienced 'first hand.' Due to the very specificity of the activity, these findings extend our understanding of how doing being a reasonable patient and therapist have emerged in an organized way. Through these multimodal and sensorial practices, therapists can balance their medical and professional authority with regard to patients' concerns particularly because

the patients are accountable for their first-hand experience and thus should take care of themselves.

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[i] The concept of *online commentary* has been described and explored by Heritage and Stivers (1999), as a physician's description or evaluation of what he or she sees, feels, or hears during a physical examination. Notably, despite the commonality of the utterance being produced "online," that is, while perceiving and/or feeling the object that they describe, the one analyzed in this paper has very different practical purposes.

[ii] This onomatopoeia conveys that the stiffness is observed like a mass and so detectable.

[iii] Though we need a systematic investigation, *ma* in this context indicates that the following formulation of observation may not be the best to capture what he wants to convey, thus, mitigating the effect of making a counter claim.

[iv] As Sakai (forthc.) observes, the therapists also utilize the noticing of a problem as a specific method to elicit an account of the patient's own problem.