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Social Interaction

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Disruptive Touch and Accountability: Embodied Disalignment in Physical Examinations During Medical Consultations

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Abstract

Using multimodal conversation analysis, we investigated a phenomenon in which the organization of physical examination in the medical consultation is disrupted by patients' embodied displays of pain and withdrawal from the doctor's touch, and doctors' practices in managing those withdrawals. Such instances break the organization of the interaction and can thus be seen to encode patients' disalignment with the ongoing activity. We present how the participants orient to the disalignments as accountable and, with that, restore the organization. The data consist of Finnish general practitioners' consultations with patients suffering from upper respiratory tract problems.

Keywords: touch, physical examination, medical consultation, embodiment, multimodal conversation analysis

1. Introduction

Physical examination is an integral part of medical consultations in healthcare interactions. In physical examinations, touch is an essential tool through which doctors gain information for diagnosing the patient. However, as the doctor's touch requires temporarily breaching the patient's area of intimacy, touch may represent a problem for patients who need to act according to their institutional roles and subject their bodies to being palpated. In general practice consultations with upper respiratory tract symptoms, touch occurs routinely, with doctors physically examining patients to diagnose them. The physical examination entails inspecting a patient's lungs, ears, throat, glands, and sinuses, with the order alternating based on the described symptoms. In the present study, we focus on the physical examination of patients with upper respiratory tract symptoms from the perspective of touch and embodied actions.

As Christian Heath's (1986, 1988) studies on interactional organization in medical health care have shown, starting a physical examination at the medical consultation involves elaborate interactional work. Prior to beginning the physical examination, both doctor and patient collaborate in displaying 'civil inattention' to each other (the term introduced by Goffman, 1963). Notably, doctors are shown to project their actions in non-verbal ways before shifting from a phase to another (Robinson & Stivers 2001). Usually after history taking the doctors proceed to physical examinations. Doctors may cue the shift with finishing words like "alright" or "okay" deployed in third turn position (Beach 1995a, 1995b) and non-verbally by settling their note taking tools, (Robinson & Stivers 2001) or by preparing the instruments required for inspection such as otoscope and spatula. The patients are shown to observe this and prepare their body accordingly (Ibid.) Thereafter, the patient engages in a 'middle-distance orientation', where they render their body to be examined as an object of the doctor's operations, turning their gaze to a middle distance while still being able to follow the doctor's inspection on the periphery and adjust their actions accordingly. Thus, the shift to physical examination is managed by co-operation between doctor and patient: the participants monitor each other's movements and align their own movements to create the necessary positions for the examination (Heath 1988, 2006). In most cases, patients yield to doctors' operations without showing signs of discomfort. However, in our analysis, we find that some patients do react vocally or non-vocally to the doctor's examination. These occurrences may disrupt the consultation and cause trouble for both participants.

Heath (1989), McArthur (2018) and Weatherall et al. (2021) address patients' pain cries and show how patients tend to allocate those cries within the organization of talk during physical examinations. Here, we examine cases in which patients seem to resist a doctor's actions, showing discomfort or pain, and thus create a rift in the interaction that is repaired by the doctor and the patient. These disalignments with the activity initiated by the doctor are observable in patients'

sudden body movements or vocalizations that rupture the progress of the physical examination. We present these examples where participants 'go out of play' (Heath, 1989) and analyse in detail the ways in which these disalignments are treated by the participants. Thus, our focus is on cases where the organization of the physical examination is momentarily disrupted. We show what kinds of embodied and verbal means doctors use to respond to the trouble and continue the physical examination after disalignment. These means can be allocated on a dimension of patient-centred vs. task-centred approaches. Importantly, we describe how these disalignments are oriented to by the participants as accountable, as deviations from the normal flow of the examination. The practice of accounting normalizes the situation and re-establishes the social organization of the encounter.

Heath (1989) and McArthur (2018) have shown that patients situate their pain cries at specific points during physical examinations so that they support the organization of the ongoing activity. Our focus, on the other hand, is on cases where this organization is disrupted and then quickly restored. Hence, we point out that interaction in intensively affective sequences such as a patient being exposed to pain or discomfort is not always orderly, but harmony can be recovered soon after the disruption.

Our focus is on touch and embodiment in the physical examinations of patients with respiratory tract symptoms, on cases where the patients slightly resist the ongoing procedure and on the ways in which the doctors and the patients react to these events. Our data consist of Finnish general practitioners' consultations that involve one patient and one doctor and our method is multimodal conversation analysis (CA; see e.g., Mondada 2019a). We show how these disruptions are dealt with by both participants and especially how the doctor manages the event. We discuss our results in relation to previous CA studies on pain during medical consultations. As follows, we briefly consider the topic of touch in health care interaction, explain our take on the integral concept of disalignment, present earlier CA studies on pain displays in healthcare encounters and discuss their relation to the present study.

2. Touch and Disalignment

Touch has been described as the most primal of our senses (Cekaite & Mondada, 2020, p. 2). At moments of high distress, such as a serious illness shutting down one's body, touch is one of the last senses that a person loses, whereas senses like sight and hearing that may require higher cognitive functions stop working first (Uotinen, 2011, p. 1311). In Marcionowicz et al.'s (2010) interview study, which focused on patient satisfaction with medical consultations, two analysts counted mentions of non-verbal cues in transcribed patient interviews; the most frequently perceived non-verbal cues from the doctor were tone of voice and eye contact. However, touch was seldom

perceived or described by the participants (Marcionowicz et al. 2010, p. 85). In medical consultations, touch is part of the routine institutional procedure that is to be expected in the context of a physical examination. Thus, it may be viewed as belonging to the realm of 'the seen but unnoticed background expectancies' (Garfinkel, 1967, p. 36).

In our study, the touch that is most prevalent is instrumental in nature, meaning that it is deployed to achieve a certain institutional task, such as a physical examination. It may also be done with a medical instrument like a spatula. The touch we focus on is treated as disruptive in the sense that it is followed by a disalignment of action from the patient. The concept of disalignment refers to a situation where the recipient refrains one way or another from facilitating or simply fails to facilitate the proposed activity or sequence (Stivers et al., 2011, p. 21).

In the context of our study, disalignment refers to the minute but noticeable bodily withdrawal of the patient at the moment when the doctor's begins the examination or during the examination where the doctor is already investigating the patient's body but the patient is unable to maintain the required posture, for example when the doctor peers into the patient's throat and the patient pulls back. These disalignments may be very short, yet disrupt the progress of the procedure. Disaligning is not necessarily voluntary; it may be caused by the patient's bodily sensations. Hence, although the patient may aspire to act in concert with the physician's examination, they show embodied resistance in the form of withdrawing or flinching. Although disalignments may be involuntary, they are treated as accountable.

2.1 Pain displays

Pain is generally considered an individual's subjective experience (Weatherall et al., 2021, p. 197) that involves an involuntary reaction to a stimulus. It may also create a socially recognizable action, such as a movement of the body, a sound or a word associated with pain. Heath (1989) showed that patients tend to allocate their pain cries within the organization of talk. They produce expressions of pain during their turns and suitable gaps in the interaction and thus seldom overlap with the doctor's talk (Heath, 1989). Heath's study maintained that pain in the medical consultation is not just an individual reaction to a stimulus but is socially organized and socially produced to accomplish certain goals within the interaction. McArthur (2018) continued along similar lines, holding in her study that during a physical examination, patients utter pain cries and provide information, as motivated by the embodied manipulations of the doctor. This allows them to circumvent the possibility of being understood as asserting their actions over the practices of the doctor. The patients orient to the organization of the institutional encounter and co-construct the epistemic differences between participants (McArthur, 2018).

Weatherall et al.'s (2021) results regarding pain displays are in line with Heath's (1989) and McArthur's (2018) studies of pain in medical encounters during physical examinations; they all argue that expressions of pain are socially organized. Hence, they present how the patient's pain is not just a subjective individual experience but part of the social organization of the interaction and is provided as an objective to be perceived by the other participant (Weatherall et al., 2021).

In her later work, McArthur (2021) argues that pain displays are considered unaccountable by participants during physical examinations. This is because they are considered automatic and out of a person's control, and with them patients can accomplish actions without being regarded as interrupting the doctor or impeding the progress of the ongoing action (McArthur, 2021, pp. 268, 281). Furthermore, patients can use pain displays as resources in the examination that also help the doctor to locate the area and diagnose the trouble the patient is having (e.g., McArthur, 2021, p. 277).

Our data differ from earlier studies in that during examinations of respiratory tract problems, doctors are not trying to locate an area in pain but to find evidence of infection or other illness. In the data, we found cases in which patients disalign with the organization of the examination. In contrast to previous findings, these episodes disrupt the harmony of the interaction and the progress of the examination. On the other hand, as in earlier research, the participants repair the interactional friction immediately after it occurs. We describe the interactional trajectories leading to the disalignments and demonstrate how participants orient to return to the continuation of the procedure as soon as possible. This observation further supports the argument made in previous CA work that actors seek to maintain the social organization within an interaction. Furthermore, we show ways in which doctors go about recovering the social organization and how their strategies may differ in terms of being more patient- or task-centred, with some paying more attention to the patient's apparent suffering than others.

3. Data and Method

Our data consist of 40 consultations involving general practitioner and adult patients with upper respiratory tract symptoms; they were collected in municipal health centres in different parts of Finland in 2005 and 2006. Relevant ethical statements were obtained from the Ethical Board of Pirkanmaa Healthcare District (project number R04143). The doctors were recruited on a volunteer basis, and all patients were personally asked if they wanted to participate in the study. The participants were informed of the study's purpose and given the possibility to withdraw at any time for any reason. When we reviewed the 40 consultations, we found 10 embodied disalignments in 5 consultations. Because the reason for the patients' visits was upper respiratory tract symptoms, the

physical examinations consisted of inspecting the patient's nose, throat, lymph nodes, ears, and lungs.

The method we use, multimodal CA, focuses on the ways in and through which particular social activities are interactionally accomplished (Drew & Heritage, 1992, p. 17), such as how doctors and patients carry out a physical examination. CA perceives actions as socially organized and is interested in how this organization is produced in conversation (Drew & Heritage, 1992, p. 17). Hence, it also studies how this social order is possible (Streeck, 2009b, 25). Our analytic focus here is the embodied disalignments that signal a temporary imbalance of the social order in the specific context of medical consultations. These cases, albeit few in number, may reveal interesting and as yet undiscovered aspects of social interactions when order is first shaken and then restored.

CA considers that participants act in ways that are intelligible to others and hold themselves morally accountable for their actions (Drew & Heritage 1992, p. 17; Heritage 1984, 5). Multimodal CA is focused on the different modalities people use to interact with one another, such as gazes and gestures, and considers the whole body: its posture, body torque and movements. The interest lies in the interactional space that the participants configure in the ongoing action (Mondada 2019b, p. 64).

4. Analysis: Disalignment From Physical Examination

In the analysis section, we present how the examinations are jointly enacted by the participants, moment by moment. We highlight the key analytical aspects and then discuss their essential meanings in the framework of our argument. We present three extracts from physical examinations performed on patients in which a disalignment from the examination occurs. The extracts range from more patient centered to more task centred approach with the doctor considering the disalignment from the patient’s point of view (extract 1) or by focusing exclusively on their own medical viewpoint (extract 3).

We demonstrate cases in which the patients disalign with the examination procedures and display how these interruptions are treated as accountable by both patients and doctors. Although disalignments may be caused by patients’ bodily reactions and patients may present their actions as something out of their control, both patients and doctors account for disaligning with the doctor’s procedures. We show different kinds of responses from doctors to patient discomfort. The arrows mark the embodied disalignments and other transcription symbols are found in the appendix.

Extract 1.

In our first disalignment case, we show how the doctor instantly reacts to the patient's apparent pain reaction and physically pulls back the otoscope.

Fig. 1

Fig. 2

1 **D joo (.)@kato[taas] se korva.%@**

okay(.)@let's [check] the ear%@ **(fig1)**

D @.....@starts examining ear-->

P % turns head to present ear

2 **P [(se on)]**

[(it is)]

3 (0.3)(- -@% -)

D -> @inserts the otoscope to P's ear

P -> %pulls head slightly away from the doctor, squinting eyes **(fig2)**

4 **D -> @se on näin hel:lä,**

@it is so sen:sitive,

D -> @retracts otoscope, readjusts, and continues examining -->

5 (0.5)((D examining P))

6 **P se meni (piloille) ku mä (.)**

it was (ruined) because I (.)

7 **P (yli) reagoin [( )**

(over) reacted [( )

8 **D [°joo:?°**

[°yeah:?°

When the doctor announces, ‘Let’s check the ear’, the patient turns their body and head to present the ear (line 1). The doctor proceeds to the examination by placing an otoscope on the patient’s ear (line 3). The patient squints their eyes and pulls their head slightly away from both the otoscope and the doctor, disaligning from the examination (line 3). The doctor reacts quickly by pulling back the otoscope and with a slight rising tone of voice requests confirmation from the patient that the ear is so sensitive (line 4). Hence, the patient’s reaction is met with an immediate embodied response from the doctor, who retracts the otoscope immediately after the patient has shown discomfort by retracting and squinting.

Following the doctor’s retreat from the patient and the question about the ears, the patient says they have overreacted (lines 6-7), most likely referring to their reaction to the ear examination, this way accounting for the disalignment. The doctor’s suggestion that the patient’s ear is “so sensitive” shows understanding of the patient’s flinching away from the examination by giving it an explanation from the patient’s point of view: the patient’s ear is sensitive to pain. Thus, it is interpretable as an empathetic comment (e.g., Ruusuvuori 2005). By giving a potential reason for the patient’s gesture, the doctor also accounts for the disalignment. As the question is of the patient’s experience, it makes relevant the patient’s confirmation and may thus prompt the account the patient gives later in lines 5-6. As the doctor suggested a potential reason for the disalignment in the form of a request for confirmation, the patient could have just given it. Instead they offer a more elaborated account in the form of self-blame for ruining the examination. The patient’s account is met with a minimal acknowledgement by the doctor, who then continues the ear examination (line 8). The discord in harmony is repaired in a matter of seconds, and the doctor may continue the examination.

The patient in this example is co-operative with the required posture but struggles with it due to their body’s possibly involuntary reaction to the touch or anticipation of a touch that will cause pain. Although the physical examination is in the realm of the doctor, the patient, by exposing the relevant body parts for the exam and accounting for the lack of fluency, orients to accomplishing it as something they should do and should be able to do. Their reaction to the touch thus appears to be involuntary. The doctor responds to this trouble by

immediately mediating it with a physical action and a verbal response, removing the otoscope from their ear that is possibly hurting them and showing concern.

The next extract presents a case where the doctor verbally attends to the patient's displayed discomfort but does not interrupt the examination.

Extract 2.

In the second doctor–patient encounter, the patient disaligns from the examination due to a pain reaction, and the doctor responds to this verbally. Unlike in the first extract, the doctor here does not momentarily halt the examination but continues it, and verbally acknowledges the patient's pain. There is an aspect of anticipation from both participants towards the pain reaction that is observable in the doctor's verbal preparation before the examination and the patient gasping right before the inspection starts (lines 1–7).

The patient's nostrils and ear have already been examined, and the doctor is moving around the patient toward the other ear, announcing their intent to inspect the ear; the patient is following the doctor with their gaze.

```
1  D   .hh ja nyt@ mä katson tältä puolelta% että@ (.)
       .hh and now@ I  will check from this% side that@ (.)
   D            @extends arm to patient's ear (fig3) @ touches the ear -->
   P                                          %turns head to present the ear

2  D   .h täs on tosiaan nytte toi on paksuuntunu tossa
      .h  here it seems that it has swollen from there

3  D   ja mä en tiedä pääsenkö mä ollenkaan et jos mä (.)
       and I don't know if I can get there at all so if I (.)

4  D   vähän venytän [tätä
        strectch     [this a bit

5  P              % [se hh (.) s[e joo @se
                  % [it hh (.) i[t yes @it
                  %gasping for air
6  D                            [joo?, @
                                 [yes ?,@
                -->                      @begins examination,
```

7 D (1.0) inserts otoscope to the ear, crouches to investigate the otoscope pushing with the otoscope and possibly still stretching the ear[1]

Fig. 3

Fig. 4

8 **P** → **%se sat(h)tu[(h)u]**
%it hur(h)ts[(h)]
P → %pulls their head back reacting to pain, grinnin/smiling **(fig4)**

9 **D** **[joo]: se varmasti sattuu=tuntuu vähän**
[yes]: surely it hurts=feels a bit

10 **D** **inhottavalta. .hh ja [( )**
uncomfortable. .hh and [( )

11 **P** **[aamulla ku vähän**
[in the morning when I

12 **P** **siirsi itte ni sattu k(h)u**
moved it myself it hurt w(h)en

[1] the doctor is inspecting an ear that is invisible to the camera angle. the stretching can be only assumed from their talk. the approaching of the patient and pushing in with the otoscope and the patient pulling back from that can be confirmed from the tape

13 **P** **pe[si (tuolta]) korvan takkaa (vähän)**
I wa [shed (from]) behind the ear (a bit)

14 **D** **[joo.]**
[yeah]

15 **D** **joo.**
yes.

The doctor extends their arms to reach the ear and says that they are going to check the other side (lines 1–2). They direct the patient's head by gently touching the ear, to which the patient responds by showing their ear to the doctor (line 1). The patient positions their head in the required way when they are being touched and guided to it. The appropriate posture for the examination is accomplished in embodied co-operation. The doctor anticipates a problem with the examination by noting that the area of inspection has swollen, and they are not sure if they can access the ear channel (lines 1–4). This may serve as a warning for the patient about some pain to be anticipated (cf. Heritage & Stivers 1999 on online commentary), this way attending to the patient's possible discomfort. However, the doctor's turn is not attending to the patient's but their own action and the potential difficulty in conducting it. When the doctor says they are going to stretch the ear while touching it, the patient gasps for air and begins to say, 'Yes, it …', preparing for the possibility of pain (line 5). The doctor immediately answers saying yes, further indicating they expect some trouble (line 6) and begin the inspection by inserting the otoscope into the patient's ear and gazing into it. Immediately, the patient recoils slightly, pulling their head back saying that 'it hurts' while simultaneously exhaling and smiling (line 8). By verbalizing the reason for the disalignment, the patient orients to it as accountable. The doctor responds by saying, 'Yes, it surely hurts', but they do not pull back the otoscope or cease the examination (lines 9–10). The doctor thus acknowledges the patient's pain by first validating the patient's experience and then downgrading the evaluation somewhat by saying that is feels a bit uncomfortable. Yet, the doctor goes on with the examination, unlike in extract 1 where the doctor ceased the examination for a moment before resuming it. The patient begins to explain that the ear hurt earlier in the morning when they washed it (lines 11–13). The doctor responds to this with a minimal acknowledgement and then proceeds to report what they see in the ear (line 15).

The patient accounts for their disalignment first by delivering their complaint 'It hurts',, beginning from line 5. This is an immediate verbal account of pulling their body away from the doctor in line 8. The smile in this context enforces the nature of the patient's action as delicate, as something unexpected in the present context (Haakana 2001), while the exhale is interpretable as emphasizing the pain sensation of the patient. Furthermore, the patient explains that they noticed the ear hurting earlier when washing it, giving a second account as a reason for the disalignment (lines 11–13). Both accounts are delivered with laugh particles,

conveying a sense of the delicacy of the trouble, or troubles-resistance (Jefferson 1985; Haakana, 2002, p. 1509).

In this extract, touch plays a more definite role than in the first extract in guiding the patient to the position of the clinical object. The doctor uses touch to 'shepherd' the patient's head into the correct position (cf. Cekaite, 2016). Although the patient reacts to the examination by flinching, they maintain the role of a clinical object and uphold the required position after the disalignment. As in the first extract, the patient shows their orientation to the embodied retrieval from a disalignment by accounting for it. In comparison to extract 1, in which the doctor momentarily ceases the examination after the patient's reaction suggesting an account for the patient's disalignment to be confirmed by the patient, here the doctor manages the disalignment by continuing the examination while recognizing the patient's uncomfortable feeling, and this way also orienting to the accountability of the disalignment.

Extract 3.

Our third example shows an approach from yet more task-centred end of the patient-centred—task-centred continuum. The doctor is investigating the patient's pharynx. The procedure is difficult for the patient, which is foreshadowed by their announcement beforehand (line 1). As in extract 2, the doctor mediates the discomfort of the patient verbally and validates the patient's painful sensation, but following the disalignments, the doctor persistently continues the examination despite the patient's apparent struggle until it turns out that it has to be interrupted altogether.

The doctor is finishing their verbal examination and has begun approaching the patient with a spatula and otoscope, moving slowly towards the patient while asking questions. When the doctor extends their arms to begin examining the throat and says, 'Let's check the mouth', the patient first opens their mouth for the spatula, orienting to the verbal and embodied cues that the examination is coming, but just before the doctor is about to begin the procedure, the patient warns that they are quite sensitive (lines 4–5).

```
1 D @#joo. (.) okei.# .hh sit katotaa
    @#yeah. (.)okay. # .hh then let's check
  D @extends arms to inspect pharynx area with otoscope and spatula

2 D  sinn[e ↑suuh-@
     th[e   ↑mout-@
  D           -->@ stops spatula in front of P mouth

3 P        [mä oon aika
           [I am quite

4 P   arkah.@ (0.4) varo, (.) h[m h' %
   sensitive@(0.4) watch out, (.) h[m h'%
  P                                  % smiles/laughs
  D          @ pulls spatula and otoscope from P


5 D                               [joo.@ (.) joo. mä- mä vielä
                                 [yea.@ (.) yeah. I-  I will
  D                                   @gestures with finger and hand

6 D   kerran %@ka[tson nyt sen@
   once more &@ ch[eck it now
  P           %opens mouth
   D           @begins to approach with spatula-->

7 P               [joo. (.) joo.
                   [yes. (.) yes.
8  (.)
```

In lines 3 and 4, we can see how the patient accounts for possible upcoming problems in positioning themself as a clinical object to be inspected before the actual exam starts. It is noteworthy how they mark their comment with laugh particles to indicate the potential delicacy of the comment (see, e.g., Haakana, 2002). As the patient starts speaking, telling that they are quite sensitive and requesting the doctor to watch out, the doctor momentarily stops and pulls the spatula partway back (line 4). Unlike in the previous extracts, the doctor does not comment on the patient's trouble announcement nor the warning about sensitivity but continues the examination stating that they will have a look once more. (lines 5–6). Thus, the patient's 'pre-account' for their potential upcoming disalignment with the procedure is received with the doctor sticking to the expected procedure nonetheless.

9 **D** **joo:?@ (.) .hh ja tota (.) mä katson et sul on vähä**
yes:?@ (.) .hh and well (.) I see that you have a bit of
D -->@begins inspection with spatula

10 **D** **(.) #ööää# (0.3) suussaki tommost vähän niinku**
(.) #umm# (0.3) in your mouth a bit like those

11 **D** **rakkuloisuutta tos[sa kielessä,**
blisters the[re on the tongue

12 **P** **[nn.**

13 **D** **työnnätkö kielen ihan %@ulos=hyvä.**
could you push the tongue%@ out=good.
P %pushes tongue out, retracts it immediately
D @inserts spatula on top of tongue

14 (.)

15 **D** **hh sitte (0.3) sanotko vielä aa.**
hh then (0.3) could you say aa.

16 (.)

17 **P** **aaa. @**
D @reaches to the pharynx with spatula

18 (0.7)

19 **D** **>joo (.) [nyt mä (.) ihan vähän ( ) ( )<**
>yea (.) [now I (.) just a little( ) ( )<

20 P [aa.

21 **D → ja @%viel[ä (.) ker#ran aa,#**
and @% on[e (.) mo#re time aa,#
D @pushes with spatula
P → %pulls head back while saying "aa" **(fig5)**

22 **P** **[aa.**

23 (.)
24 **D** **sanotko vielä,**
say one more time,

25 (1.0)

26 **P** **yä'%@**
P → %pulls head back slightly
D @retracts the spatula, pulls away from P

27 **D** **joo.%**
yeah.
P % closes mouth

Fig. 5

In the ensuing examination starting at line 6, the doctor continues to inspect the patient's throat despite the embodied disalignments. After commenting that the patient has blisters on their tongue (lines 10–11), they ask the patient to push out the tongue (line 13). The patient shows their tongue but immediately pulls it back when the doctor places the spatula on it (line 13). The doctor continues by asking the patient to say 'aah' (line 15). After the patient complies, the doctor tries again and asks the patient to say 'aah' (lines 19–21). When the doctor reaches the pharynx by pushing the tongue with the spatula, the patient pulls their head back, once again temporarily disaligning with the examination (line 21),

The doctor continues with the examination, instructing the patient to say 'aah' again while trying to see the patient's pharynx and still holding the spatula in their mouth (line 24). After the third attempt, the patient slightly pulls their head back while making a distorted 'aah' sound and disaligning from the action. The doctor retracts, responds 'yeah' and pulls away from the patient (lines 26–27). However, the doctor keeps the medical instruments in their hands, indicating they are not yet done and makes yet another attempt to examine the patient, as we see in the continuation of the extract:

28 D **@[.hhh (.) työnnätkö ihan kielen °ulos vielä°.%**
@[.hhh (.) could you push the tongue completely °out once more.°%
D @gestures with right hand
P %gestures by smiling, shaking haed once to the right and back toward the D, shifting their position in the chair -->

29 (0.3)

30 D **kokeillaan vie[lä.**
let's try aga[in

31 P **hh.% [vaikeeta.**
hh.& *[difficult.*
P &smiles

32 D **>joo. .hh se on< aika ärtyneen näkönen nimittäin mut**
>yeah. .hh it is< quite irritated looking actually but

33 D **mä näen vaan [sen ihan %yläosan sieltä ni, @**
I can only see [only the %upper part from there so, @
P %opens mouth
D @approaches to inspect mouth -->

34 P **[kr-krrh. rh.**

35 (.)

36 D **@no niin nyt näkyy ( ) ja nyt@ (0.5) nyt vielä (.)**
okay now I can see ( ) and now@ (0.5) now again (.)
D @crouches to look in the mouth @inserts spatula

37 D **tota: (0.5) sanot#ko aa.# @**
umm: (0.5) coul#d you say aa.# @
D @pushes spatula further in the throat

38 (.)

39 P → **%e.**
P → %pulls head back **(fig6)**

Fig. 6

```
40 (.)
41 D   jooh @h'[h'h %
       yeah  h'[h'h
   D         @smiles, retracts spatula (fig7)
   P                  %closes mouth, looks down, shakes head

42 P   [((nielaisee äänekkäästi))@ %
       [((swallows loudly))      @  %
   D                              @retreats from P to midway
   P                                %lowers head smiles slightly (fig8)
43          (1.2)

44 D   @.hh tuleeks% sulla helposti ihan oksennu[s sit°teh.°
        @.hh do you% easily feel like  puk[ing th°en? °
   D   @stops smiling, gestures with right hand
   P                %raises head to look at doctor

45 P                                                %[tulee.
                                                    %[yeah.
   P                                                %nods
```

Fig. 7

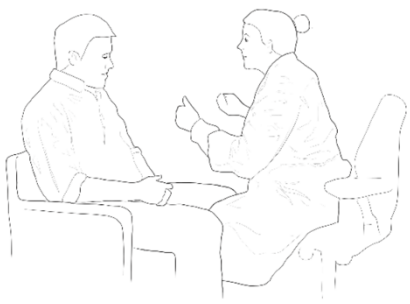

Fig. 8

The doctor again asks the patient to push out their tongue (line 28) whereupon the patient shakes their head once and shifts in their chair while smiling. The doctor treats this as a non-verbal refusal and reorients to the task by suggesting the patient to to try again (line 30). The patient accounts for their earlier noncompliance by saying “Difficult” (line 31). The doctor validates the patient’s

account by confirming from their own perspective that the throat is looking irritated but goes on to explain why they need to continue (line 32-33), thus keeping to more task-centered activity (cf. extract 1). At this point the patient opens their mouth again, and the doctor goes on with the examination.

In this attempt to examine the throat, the doctor again puts the spatula on top of the tongue and pushes further while asking the patient to say ‘aah’ (line 37). The patient makes an ‘eh’ sound and pulls their head back, disaligning with the ongoing examination activity (lines 39). The doctor responds to this with a ‘yeah’ and notably laughs briefly and smiles while momentarily ceasing the examination. The patient looks down, smiles a little and moves their head from side to side (lines 41–42) a movement resembling of shaking their head. The doctor presents an explanation for the potentially embarrassing moment and accounts for the patient, this time from the patient’s point of view, asking if they feel the need to vomit easily, to which the patient replies ‘yes’ in a low voice (lines 44–45).

Fig. 9

Fig. 10

46 (.)

47 **D** **>joo.<@ (.) .hhh no koitetaan vielä, (.) mä en paina tätä**
>yeah.<@ (.) .hhh well let's try again, (.) I won't press with this
D @extends otoscope, gestures with hands

48 **D** **tikkuu ollenkaan (.) (vielä% työnnä @kieli ulos) sano aa.**
stick at all (.) (again% push @tongue out) say aa.
P %opens mouth, pushes tongue out
D @moves to inspect mouth with otoscope without spatula -->

49 (0.3) (D peering into patient throat)

50 **P** **ää. (0.3) ää. (0.4) @ää:h.**
D @ moves spatula closer to P and retracts it immediately to midway looking at P mouth

51 **D** **#joo e[i ( )#**
#yeah n[o ( )#

52 **P** **[#ää:h.#**

53 D (1.5) (D moves spatula in front of P mouth)

54 **D** **#jo[oh.#**
#ye[ah.#

55 **P** **[ää. (1.1) ää.**

56 (0.6) (D holding spatula in front of P mouth)

57 **D** →**@>joo. (.) nyt ihan pikkusen viel@% (.) [joo. (.)**
@>yeh. (.) now just a little bit@% (.)[yeah. (.)
D @inserts spatula **(fig9)** @pushes spatula into pharynx
P → %pulls head back**(fig10),** retracts tongue

58 **P** **[äng**

Fig. 11.

59 **D** **katotaas @%viel=työnnä kieli viel iha,% (.)**
let's check@% again=push your tongue out,% (.)
D @retracts spatula
P %closes mouth %opens mouth

60 **D** **ny-% nyt mä katon viel ton @(ton tikun).<**
no-% now I'll check again with@ (the stick) .<
P %closes and opens mouth
D @pushes spatula into pharynx

61 (0.3)

62 D **>joo.< (1.3) joo::? hh.**
>yeah.< (1.3) yeah::? hh.

63 (1.4) (D using the spatula to inspect the throat)

64 P → **%khhä@hhäh eei. %**
%khhä@hhäh noo. %
P → %pulls head back**(fig11)**, closes eyes, grimace/smile
P %closes mouth,
D @retracts spatula

65 D **j[oo. .hh@**
y[eah. .hh@
D @retreats from P, turns torso right towards table

66 P **%[(se) on kyl aika vaikee°ta.°**
%[(it) is quite difficu°lt. °
P %smiling

67 D **tota:m- (0.3) .mt**
well:m- (0.3) .mt

68 (0.9)

69 P **krh-[krh-krhh.**

70 D **[( ) se=mä katon nyt näit muita (.) asioita**
[( )it=I will check the other (.) things

The doctor acknowledges the patient's answer and informs the patient of a new effort without pressing with the spatula, this way changing their approach to presumably less difficult for the patient to endure. They ask the patient to produce "aa" again, while already approaching the patient with the otoscope (lines 47-48). They bring the spatula in front of the patient's mouth and eventually use it to depress the patient's tongue (lines 53-57). Again the patient pulls their head back, and disaligns with the suggested activity (line 57). The doctor retracts the spatula asking them to push their tongue out (line 59) and then tries again while saying that they will this time use the spatula (line 60), which after the patient maintains their position for few seconds (lines 61-63) but eventually pulls their head back again disaligning with the operation (line 64). While pulling back the patient's grimace delivered with troubled laughter turns into a smile and they end their turn by saying 'no' (line 64). The doctor retracts the spatula, pulls away from the patient, acknowledges the patient with "yeah" and turns towards the computer screen, marking the examination ended (lines 64-65). The patient explains while smiling that 'it is quite difficult', giving an account for their troubles (line 66).

In this extract, we can see that when the patient disaligns from the procedure, they orient to it as accountable, and also something that is possibly embarrassing, as indicated by the patient's laughter at the relevant turns (lines 4, 28-31, 42, 64; Haakana, 2002). The patient tries to complete the examination, but due to their bodily reactions to the spatula, possibly due to illness or a gag reflex, their body cannot comply. Furthermore, the patient in two cases momentarily disaligns with the procedure verbally when they present their body as potentially uncontrollable by saying they are a bit sensitive (lines 3-4), and when they declare the examination to be "difficult" while accounting for their previous embodied disalignment on line 31. The doctor's actions in this case are persistent in accomplishing the examination, despite the various embodied disalignments by the patient. Finally, however, the doctor must stop the examination altogether due to the patient's embodied reaction.

After the patient's pre-warning of being sensitive and the following disalignment (line 21) and the more prominent disalignment at line 26-27, the doctor continues the physical examination without comments or accounts. At lines 28-31, when the patient initially declines the doctors suggestion by shaking their head and stating that it is difficult, the doctor requests to continue the examination, keeping their focus on the institutional task. Only the patient's next disalignment at line 39 results in the doctor retracting and accounting for the disalignment from the patient's perspective. Following their last effort to continue the examination and facing the patient's prominent disalignment, the doctor finishes the examination without further comments. While the doctor does validate the patient's account at line 32-33, and volunteers an account for the patient's disalignment (line 44), they keep their focus on continuing the examination despite the patient's evident troubles. Extracts 2 and 3 both show cases in which the patients strive to maintain their bodies in the form of clinical objects, but when those bodies resist and the process of inspection is halted, it is responded to with a display of embarrassment or an account.

5. Discussion

In this article, we have shown how doctors and patients solve patient disalignments that occur during physical examinations. These disalignments occur in situations where a doctor's approaching to start or actually starting a physical examination observably causes pain or discomfort in anticipation of pain for the patient. The doctors' ways to respond to the patients' disalignment ranged from patient-centred to task-centred. In the more patient-centred approach, presented in Extract 1, the doctor both ceased their procedure temporarily to volunteer an explanation for the disalignment immediately following it, providing the account from the patient's perspective and this way attending to the patient's experience ("so sensitive", Extract 1). Such approach can be interpreted as showing empathy by giving space and attending to the patient's feeling body. In contrast, in the more task-centred approach presented

in Extract 3, the doctor persistently continued with the examination despite the patient's various disalignments signalling their discomfort, mostly not commenting on the patient's trouble or commenting them from the doctor's perspective ("It looks quite irritated actually", extract 3). Rather than making a dualistic division, we find that such approaches, patient- or task-centred, appear on a continuum. For instance, in Extract 2, we presented a case where the doctor continued the procedure while verbally acknowledging the patient's expressions of discomfort.

Our study initially hints at that there is a positive connection between a doctor's patient -centred approach and successful continuity of the potentially pain-causing procedure. That is, even if deviations from the usual sequential order of physical examinations to attend to the patient's feelings may, at first glance, seem like hindering the process, attending to the patient's embodied displays of discomfort and validating their accounts from the patient's perspective may actually, in contrast, end up forwarding the smooth progressivity of the physical examination. For instance, in Extract 3, the doctor forcing to move on with the examination ended up failing to finish the examination; at the same time, in the Extract we also witnessed emerging frictions in the institutional social relationship between the patient and doctor, manifested in the patient's expression of embarrassed laughter and ambivalent emotion expressions (e.g., grimace of pain accompanied with a smile (Figure 11), and an a response showing negative emotion, line 64). In our collection, we found that embarrassment as an interactionally observable emotion was often managed through or masked as laughter to recover the emergence of potentially delicate social situation. While the embarrassment may have stemmed from the patient momentarily losing control over their body (something that is possibly unexpected by adults in western societies such as studied here, Finland), in Extract 3 especially we also suspect that the patient's expression of embarrassment may have stemmed from the lack to doctor's empathetic validation on the patient's trouble. However, more research with larger datasets would be needed to study the kinds of possible combinations of patient- and task-centred strategies that might best meet both clinical purposes and enhance patient satisfaction.

An important observation was that throughout the collection, including both patient- and task-centred case, the participants collaboratively accounted for the disruptions, although they could easily be seen as not unexpected in physical examinations. This orienting to accounting speaks for the tendency of interactors, both the doctor and patient, to return to the common, possibly normative order of the interaction in medical consultations in the phase of physical examination.

In earlier CA studies of pain in medical consultations (Heath, 1989, 2006; McArthur, 2018, 2021; Weatherall et al., 2021), the phenomenon of pain has been viewed as part of the medical context and the interactional activity. It is

managed within the framework of diagnostic activity and hence does not evoke sympathy from the doctor (Heath, 1989; Jenkins & Hepburn, 2015, p. 476). Our results differ from these earlier studies. In our data, the aim of the examinations the doctors perform is not to locate an area that is hurting but a possible area of infection, which may explain the differences in the participants' actions. In our study, pain is disruptive and causes a disalignment that is oriented to as accountable by both participants. The doctors respond either verbally or physically to causing pain, and both the patients and doctors orient to it as something possibly embarrassing and worthy of accounting for.

As such, our viewpoint on pain is in alignment with McArthur (2021), who argues that pain can be viewed as analogous to emotion due to their similar mechanisms in social orientation. Both are oriented to as something possibly uncontrollable and thus unaccountable. However, while we agree with McArthur in her suggestion that a good way to approach pain and emotion in interaction is to analyse their 'use' in conversation – that is, as action-oriented resources, and not merely automatic reactions to internal experiences of pain – our analysis hints at more nuanced relationship between the usually contrasted internal and external expressions of pain in interaction. The patient's involuntary and uncontrollable expressions of internal pain may be viewed in concert with the interactional 'uses' of such expressions. In our analysis the patients uncontrollable feeling bodies exhibit agency of their own in the organized, structured institutional interaction in a way that is not completely reducible to interactional 'use' of emotion; all actions of the body are not necessarily designed for interactional purposes. At the same time, the analysis shows the participants deep commitment to restore the interaction order.

As such, it may also be worth investigating how automatic or involuntary reactions appear and are treated and oriented in social interaction. Katila and colleagues (e.g., Katila, 2018; Katila & Raudaskoski, 2020; Katila & Philipsen, 2022; Katila et al., 2023) have suggested that especially in investigating tacit interactions such as proximity and touch, CA methods may not suffice to explain what is going on. Following Merleau-Ponty's (1962) idea of intercorporeality (see also Fuchs, 2017), Katila and colleagues suggest that researchers could use their own accumulated experience of bodily sensations that resonate with those of the observed participants to delve deeper into their interpretations of ongoing interactions. Adopting such new methodological approaches in future studies may afford novel and interesting perspectives on the ways in which subjective experiences such as pain become observable, shareable, and manageable in social interactions.

In our data, we found only 10 cases of disalignment in adult consultations from a dataset of 40 cases. This may be due to adults being socialized for physical examinations, and it is to be expected that they will maintain the required postures for the operation, despite the trouble that may cause them (e.g., Katila et al. 2025). Furthermore, despite the possible infections that the patients in our

study might have had, doctors are most likely able to inspect the required areas without causing too much discomfort. However, despite the lack of an abundance of examples, the cases we present offer a fruitful window onto how embodied disalignments are oriented to in examinations and how harmony is quickly restored by the participants.

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References

Beach, W. A. (1995a). Conversation analysis: “Okay” as a clue for understanding conse quentiality. In S. J. Sigman (Ed.), *The consequentiality of communication* (pp. 121–161). Hillsdale, NJ: Erlbaum.

Beach, W. A. (1995b). Preserving and constraining options: “Okays” and “official” priorities in medical interviews. In B. Morris & R. Chenail (Eds.), *Talk of the clinic: Explorations in the analysis of medical and therapeutic discourse* (pp. 259–290). Hillsdale, NJ: Erlbaum.

Cekaite, A. (2016). Touch as social control: Haptic organization of attention in adult–child interactions. *Journal of Pragmatics, 92*(1), 30–42. https://doi.org/10.1016/j.pragma.2015.11.003

Cekaite, A., & Mondada, L. (2020). *Touch in social interaction: Touch, language and body*. Taylor & Francis Group.

Drew, P., & Heritage, J. (1992). Analyzing talk at work: An introduction. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 3–65). Cambridge University Press.

Fuchs, T. (2017). Intercorporeality and interaffectivity. In C. Meyer, J. Streeck, & J. S. Jordan (Eds*.), Intercorporeality: Emerging socialities in interaction* (pp. 56–76). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780190210465.003.0001

Garfinkel, H. (1967). *Studies in ethnomethodology*. Prentice-Hall.

Goffman, E. (1963). *Behavior in public places. Notes on the social organization of gatherings*. The Free Press.

Haakana, M. (2002). *Laughter in medical interaction: From quantification to analysis, and back*. Blackwell.

Heath, C. (1986). *Body movement and speech in medical interaction*. Cambridge University Press.

Heath, C. (1988). Embarrassment and interactional organization. In P. Drew & A. Wootton (Eds.), *Erving Goffman: Exploring the interaction order* (pp. 136–160). Polity Press.

Heath, C. (1989). Pain talk: The expression of suffering in the medical consultation. *Social Psychology Quarterly, 52*(2), 113–125. https://doi.org/10.2307/2786911

Heath, C. (2006). Body work: The collaborative production of the clinical object. In J. Heritage & D. W. Maynard (Eds.), *Communication in medical*

care: Interaction between care physicians and patients (pp. 185–213). Cambridge University Press.

Heritage, J. (1984). *Garfinkel and ethnomethodology*. Polity Press.

Heritage, J., & Stivers, T. (1999). Online commentary in acute medical visits: a method of shaping patient expectations. *Social science & medicine (1982), 49*(11), 1501–1517. https://doi.org/10.1016/s0277-9536(99)00219-1

Jefferson, G. (1985). On the organization of laughter in talk about troubles. In J. M. Atkinson (Ed.), *Structures of Social Action* (pp. 346–369). chapter, Cambridge: Cambridge University Press.

Jenkins, L., & Hepburn, A. (2015). Children's sensations as interactional phenomena: A conversation analysis of children's expressions of pain and discomfort. *Qualitative Research in Psychology, 12*(4), 472–491.

Katila, J. (2018). *Tactile Intercorporeality in a Group of Mothers and Their Children: a Micro Study of Practices for Intimacy and Participation*. Tampere: Juvenes Print.

Katila, J., Hofstetter E., & Keevallik, L. (2023). Cries of pleasure and pain: Vocalizations communicating how touch feels in romantic relationships. *Research on Language and Social Interaction, 56*(4), 330–349. https://doi.org/10.1080/08351813.2023.2272529

Katila, J., & Philipsen, J. S. (2022). Forms of professional interkinesthesia in nurses' body work: A case study of an infant's stepping. *Frontiers in Communication, 7*, Article 954483. https://doi.org/10.3389/fcomm.2022.954483

Katila, J., & Raudaskoski, S. (2020). Interaction analysis as an embodied and interactive process: Multimodal, co-operative, and intercorporeal ways of seeing video data as complementary professional visions. *Human Studies, 43*, p. 445–470. https://doi.org/10.1007/s10746-020-09553-4

Katila, J., Guo, E. & Cekaite, A. (2025). Shepherding the emotion: Embodied socialization of emotion *in paediatric dental interactions. Learning*, Culture and Social Interaction, 52, 100895.

Marcinowicz L, Konstantynowicz J, Godlewski C. (2010). Patients' perceptions of GP non-verbal communication: a qualitative study. *British Journal of General Practice. 60*(571), 83-7. https://doi.org/10.3399/bjgp10X483111

McArthur, A. (2018). Getting pain on the table in primary care physical exams. *Social Science & Medicine, 200*(5), pp. 190–198. https://doi.org/10.1016/j.socscimed.2018.01.012

McArthur, A. (2019). Pain and the collision of expertise in primary care physical exams. *Discourse studies. 21*(5) 522–539.

McArthur, A. (2021). Affect and accountability: Pain displays as a resource for action. In J. Robles (Ed.), *How emotions are made in talk* (pp. 263–285). John Benjamins.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. Routledge.

Mondada, L. (2019a). Contemporary issues in conversation analysis: Embodiment and materiality: Multimodality and multisensoriality in social interaction. *Journal of Pragmatics, 145*, 47–62. https://doi.org/10.1016/j.pragma.2019.01.016

Mondada, L. (2019b). Conventions for multimodal transcription. Retrieved April 2, 2024, from https://www.lorenzamondada.net/multimodal-transcription.

Robinson, J.D., & Stivers, T. (2001). Achieving activity transitions in primary-care encounters: From history taking to physical examination. *Human Communication Research, 27*, 253–298.

Ruusuvuori, J. (2005). 'Empathy' and 'sympathy' in action: Attending to patients' troubles in Finnish homeopathic and general practice consultations. *Social Psychology Quarterly 68*, 204–222.

Stivers, T. Mondada, L., & Steensig, J. (2011). In T. Stivers, L. Mondada, & J. Steensig (Eds.), *The morality of knowledge in conversation* (pp. 3–24). Cambridge University Press.

Streeck, J. (2009b). *Gesturecraft: The manu-facture of meanin*g. John Benjamins Publishing Company. ProQuest Ebook Central.

Uotinen, J. (2011). Senses, bodily knowledge, and autoethnography: Unbeknown knowledge from an ICU experience. *Qualitative Health Research, 21*(10), 1307–1315. https://doi.org/10.1177/1049732311413908

Weatherall, A., Keevallik, L., La, J., Dowell, T., & Stubbe, M. (2021). The multimodality and temporality of pain displays. *Language & Communication, 80*(5), 56–70. https://doi.org/10.1016/j.langcom.2021.05.008

Appendix

Transcript method originally developed by Mondada (2019b): https://www.lorenzamondada.net/multimodal-transcription

D = doctor, embodied action symbol @

P = patient, embodied action symbol %

The participant-designating symbols @ or % are put usually before or after a word rather than in the middle of a word. This is to enhance the understandability of the transcript. Whether they appear before or after a word depends which is closer to the beginning of the embodied action.

Example:

D 1 @[2]So I'll check your lymph nodes next

D @[3] extends arms to inspect lymph nodes

Illustrations and line drawings by Caroline Jullien

[2] Sentence line.
[3] Action line.