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# Three Voices in a Norwegian Living Room: An Encounter from Physiotherapy Practice

*This article demonstrates how uses of the body regulate togetherness and availability in clinical encounters. A first encounter between a physiotherapist and a married couple in their home is analyzed. The husband suffers from functional consequences of a stroke. The therapist's job is to assess his functional capacity and determine how he can best be helped. The article centers on the process of interaction, specifically on verbal and bodily actions pertaining to developing role negotiations. Comprehensive excerpts demonstrate that a struggle is going on between the husband and his wife over the management of information about his condition. This imposes dilemmas of control and caring on the therapist. The article describes the maneuvering of the parties and shows how the therapist manages her professional tasks. Emphasis is placed on the particular predicaments that a clinical encounter can generate in a private residence, and on how clinical tasks are embedded in social processes. Finally, the article questions the (often tacit) analytical assumption that "interaction" and "diagnostics" are separate phenomena, and shows how the understanding of both can be advanced if seen as mutually constitutive processes.* [clinical encounters, communication, embodiment, physiotherapy, visiting practice]

In modern medicine, the "art" of communication has on principle been considered something other than "real" professional work, that is, a scientifically based diagnostic and therapeutic activity. Consequently, communication has not traditionally been subject to investigation and systematic theorizing by medical and other health care professionals. In recent decades, however, health care personnel have shown increasing interest in communication. With few exceptions, the theoretical perspectives assumed and the methodological approaches applied remain based on implicit assumptions that distinguish between diagnosis and treatment of the *physical* body on the one hand, and communication between patients

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and clinicians in the form of *talk* on the other. This distinction between communication and real professional work is part of the Cartesian legacy and follows logically from the precept that the person as subject should be considered detached from the body. As the exchange of messages between *subjects*, communication has nothing to do with the body. This leaves us with disembodied subjects that communicate and mindless, silent bodies open to scrutiny and intervention. This distinction between the social aspects and the content of professional work is clearly a cultural construct, but in health care science it is usually taken for granted and treated as "natural."

To a large extent, the medical social sciences have accepted that medicoscientific knowledge is a domain largely inaccessible to investigation. This in itself demonstrates how biomedical thinking is part of a more comprehensive ideology shared by most members of Western societies (Hepburn 1988; Lindenbaum and Lock 1993; Scambler 1987; Scheper-Hughes and Lock 1987; Singer 1990; Wright and Treacher 1982). Criticism of this ideology, however, has been raised from various quarters of the social science community in recent decades. Notably, proponents of critical medical anthropology accuse conventional medical anthropologists of uncritically accepting biomedicine and not scrutinizing the biomedical orientation and the practices it gives rise to. It is correspondingly argued that medical anthropology (like medical sociology) often contributes to reproducing conventional domains of knowledge.[1] In employing the dichotomies applied by health personnel—body/mind, nature/culture, real/unreal, and their derivatives—much social science research has contributed to strengthening them.

What I particularly want to emphasize is the view of the body in this critique. In the social sciences, increasing attention is now paid to the body, and the former widespread tendency to treat the individual as a disembodied agent—thereby implicitly accepting the dualist image of "man"—is a matter of regret and is currently being revised (Bourdieu 1990a, 1990b; Connerton 1989; Lock 1993; Turner 1984). Theoretical clarifications are now emerging with respect to the implications of "double involvement," referring to how persons create society while being created by it, taking as a starting point the notion of "the embodied agent." This reorientation, however, has only just begun to influence research on clinical events. The dichotomies that health personnel and others perpetuate will only be superseded when individuals are regarded as bodily, experiential, meaning-conveying, and meaning-producing subjects. The relation between the "social" aspects and the "content" of professional work can only be explored and understood when it is realized that the body is *not* separate from the social self, and that experience is centered in the body.

The following is a descriptive analysis of a single case that is part of a broader qualitative study of 15 first encounters between patients and physiotherapists. For this study, I observed and recorded on video each encounter, which took place in the physiotherapists' normal working surroundings. Taping began as participants greeted one another and ended when they were out of one another's sight. I strove to establish a camera angle that provided full-length shots of all participants at one time. As this was not always possible, certain interactional details were not continuously recorded. Immediately after the taping, patients and physiotherapists were interviewed separately. These interviews were tape-recorded. Thus the entire set consisted of 15 video films and 30 interviews. All participants were Norwegian.

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The recorded material was transcribed and analyzed according to guidelines developed by the related schools of ethnomethodology and microethnography (Erickson 1982; Hammersley and Atkinson 1992; Kendon 1977; Ochs 1979). One of the benefits of videotapes usually stressed in the literature is that they can be played back repeatedly, thereby helping to ensure precision and reliability. I took advantage of this benefit throughout the research process. Videos are useful, too, for reviewing material when preliminary analyses of one encounter precipitate questions concerning another.

But for my purposes, the real strength of visual recording lay in its capacity to register emergent and multilevelled interaction. Analytically, I was able to concentrate first on verbal interaction, then on bodily interaction, and finally on how the two variously reinforce, complement, or contradict each other.

It must be pointed out that to watch a video playback is not quite the same thing as being there. Recordings reduce a real-life social situation in a particular setting at a particular time to sound and moving screen-images that can be replayed at will. To compensate for this "reductive translation" I chose to be present while the camera was running. This helped me to maintain a contextualized gaze in spite of being in my own workplace watching or showing the videotapes to colleagues and other researchers. Experiencing the unfolding situations directly also enabled me to cross-check recordings and transcriptions with my memory and notes, and helped me avoid the danger of having transcriptions be the only data source.

Finally, readers may want to know that the videos were offered for viewing to the participants themselves (though some declined the offer), other researchers, physiotherapists, and to physicians, thereby helping to secure validity.

The present analysis is meant to bring out (1) how roles and relations develop between the participants during face-to-face interaction, and (2) how negotiations take place between them. I pay close attention to the process of interaction and to how verbal and bodily actions within the event are organized; I do this from the perspective of the relationship between communication and diagnostic activity. Thus the notion of voice in the title refers not merely to what the participants say, to the words they utter, but includes how they present themselves, encompassing bodily expressions and interaction.

The encounter presented includes three people: an elderly man who has suffered a stroke, his wife, and a physiotherapist. The encounter takes place in the couple's home. My focus on this single encounter is motivated by a general concern for the importance of details of social interaction in specific contexts. The encounter was selected because it illustrates clearly how the clinical task is embedded in social processes. More specifically, it demonstrates that encounters involving family members require professionals to relate not only to several people, but also to their mutual relationship. Moreover, it shows how the home, as an arena for clinical encounters, challenges professionals' traditional role.

## Theoretical Perspectives

Encounters are regarded as social events during which the parties continually create content and context, each party guiding the other's actions and choices (Goffman 1967, 1976, 1981; Kendon 1977; Knorr-Cetina and Cicourel 1981; McDermott 1978; Watzlawick et al. 1967). Context, in its dynamic sense, consists

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not only of institutional and external factors, but also what participants create from moment to moment. The manifest messages exchanged become part of the particular interpersonal context and impose restrictions on subsequent interaction. Actions are not merely interpreted in relation to their context; they also help create the context and thus the premises for future actions. A central premise is that all actions convey messages, and that participating parties create meaning through action and negotiation. Thus everything that happens is of potential interest. The focus is on *how* people constitute an "active environment" for ordering each other's behavior, and on *how* these environments constrain their next activities. By adopting this perspective it becomes possible to theorize how action and interaction are sustained, and how change takes place. I draw extensively on insights from the microsociological tradition. Although my analysis is largely descriptive, I aim to augment this tradition by including bodily interaction. Here I am inspired by critical medical anthropologists—by their commitment to practice and by their willingness to go beyond the speaking subject and the inert body (Lock 1993; Scheper-Hughes and Lock 1987)—as well as by more recent theoretical works (Bourdieu 1990a, 1990b; Connerton 1989). Studies of clinical contexts rarely account for the body with respect to its social organization.

I should say that my use of the term *body* (or bodily) *communication* and not *nonverbal* is deliberate. To my mind, the latter has a negative connotation, denoting phenomena that lack something that verbal phenomena possess, and that are somehow subordinate or inferior. Since I emphasize the significance of how participants relate to each other through their bodies—as embodied subjects—I have chosen to use the more positive term.

Bodily information can be categorized in various ways. Strictly speaking, any orally mediated message represents bodily activity, such as sound, volume, tempo, and tone—qualities usually labelled "paralinguistics." Of interest here, however, are certain other aspects of bodily interaction: how persons comport themselves and relate to one another through posture, position, physical proximity, movement, gaze, and touch. That spatio-orientational arrangements and touch are devices for social regulation that people resort to in almost all contexts appears to be a cross-cultural phenomenon. Thus Connerton writes that "the choreography of authority" is expressed through the body (1989:74), and others have used the expression "micropolitical dynamics of social life" about bodily actions and communication to emphasize that bodily behavior and communication are much more than purely individual and emotional (Birdwhistell 1990; Hall 1966; Henley 1977; Scheflen 1972). In short, how we relate bodily to one another affects our prospects for contact, and hence for being understood verbally; speech is interwoven with other strands of communication.

In face-to-face interaction, therefore, communication flows along several channels simultaneously and the analyst is advised to attend not only to verbal expressions but also, and often more significantly, to "the glances, gestures, positionings . . . that people continuously feed into the situation" (Goffman 1967). Such interaction tends to be organized with respect to the physical setting in which it takes place (participants making use of its various features), and a proper "move" in an interactional exchange may consist of nothing but a barely noticeable movement or a spatial reorientation. More specifically, copresence turns participants into mutually observing audiences, and spatial and bodily orientation can promote or inhibit

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eye contact. Goffman has pointed out that "for the effective conduct of talk, speaker and hearer had best be in a position to *watch* each other" (1981:130) so as to be able to monitor one another's mutual perceptions.[2] Even when people are not in direct contact, they need to know how their neglect or disinterest is perceived so they can decide what to do next.

A substantial corpus of research confirms the general impression that people's eyes reflect their social availability (Argyle and Cook 1976; Birdwhistell 1990; Exline 1974; Goodwin 1980; Heath 1986; Kendon 1967). Yet, we may be bodily oriented toward each other without having eye contact, such as during medical consultation note-taking (Heath 1986).

## Toward a Better Understanding of Clinical Encounters

The bulk of analyses of clinical settings focus on first encounters in medical practices, often on history-taking and conversation in general. While there are certainly grounds for attaching importance to the verbal dialogue between patient and professional, the approach can produce a false impression of the actual climate of cooperation that develops during an encounter. Verbal communication does not necessarily follow the same pattern as communication by other means, for during the examination clinical tasks are being performed and laboratory data collected. In other words, participants' verbal messages do not necessarily correspond with their body communication.

Since human beings function and relate to one another as embodied subjects, messages of interest and involvement, as well as of disinterest and indifference, will somehow be conveyed through their bodies. This is one of the reasons that talking and listening are mutually constitutive processes. Accordingly, applying coupled notions such as "active-passive" or "sender-receiver" to speaker and listener respectively is problematic. It is also problematic to conceive of professionals as active and patients as passive by differentiating them in terms of power to act and responsibility for actions performed.

Analyses should take account of what happens during talk as well as when talk is not the main activity. By their very nature, clinical examinations involve certain positions, interpersonal distances, actions, touches, and so on that are integral to the type of interaction that takes place. Being basically procedural, clinical examinations tend to promote or inhibit certain patterns of interaction and role ascription. In other words, these encounters are loosely shaped by the approach chosen by the professional, and the remainder is created then and there.

## The Encounter

### *Background Information and a Brief Characterization*

According to Norwegian legislation, physiotherapists who work in the field are responsible for providing therapy to anyone above the age of 16 who cannot visit a health service office. In practice these therapists serve mainly the elderly and are commonly requested by home nurses.[3] This is the case of the encounter discussed here. The visit by the physiotherapist, a woman in her 40s, was initiated by a home nurse who provided daily care for the stroke victim. The idea was for the

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therapist to evaluate the patient's situation with a view to improving his function and prospects for self-help. Both husband and wife were pensioners above the age of 70. They lived in a spacious, single-floor villa in a suburban district that had a trim garden around it.

For analytical purposes, I break down the meeting into eight sequences, based on shifts in activities during the meeting:

- Greeting. Establishment of the climate for the conversation
- History-taking
- Functional assessment of the patient in sitting and standing positions
- Functional assessment of the patient's gait and use of technical aids
- Evaluation of the bathroom
- Evaluation of the bedroom
- Conversation; summary and proposals for further treatment
- Leave-taking

The situation is jointly defined throughout the encounter as a professional one. The therapist decides what to do, when, and how. She asks most of the questions, she controls the topics, and she evaluates what is said and done. She uses her institutionalized power to perform her professional duties, which include the functional examination and regulation of the interaction. From the outset she is explicitly telling the context, while simultaneously contributing to its creation.

Both husband and wife help ensure that the meeting remains a professional one. Thus, as far as defining the professional situation and the therapist's role as a professional are concerned, there is no power struggle. Yet there are ongoing negotiations between husband and wife about *what* information should be brought to light, *whose* opinion is most justified, and thus *who* they are—in relation to the therapist and to each other. This requires shifts in footing, and the therapist has to enter into negotiations of content, roles, and relations with both parties.[4]

The meeting is largely characterized by ongoing and focused interaction between patient and therapist, while the wife is kept on the sidelines. Husband and wife maintain distance between them, and both seek contact with the therapist, using both verbal and physical means. The three of them seldom talk together. The wife makes repeated attempts at inclusion, mainly verbal. Her participation is limited by the patient, who virtually ignores her presence, while the therapist employs other strategies.

*Greeting. Establishment of the Climate for the Conversation*

The wife meets the physiotherapist at the door. They shake hands. The wife immediately makes her presence felt by verbal and physical presentation: she talks a great deal, loudly, while keeping her back very straight and making rapid, efficient movements. The husband comes in from behind her, walking slowly and unsteadily. He fumbles a little to find words. The therapist walks toward him and they shake hands. The wife is now behind the therapist's back and they are all standing in the hall, near the entrance to the living room. The following excerpts are from the dialogue between patient (P) and therapist (T) as they face each other:[5]

T: Kari Normann.
P: What?

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T: My name is Kari Normann.
P: Kari Normann, hmmmm.
T: I'm the one you talked to on the telephone.
P: Yes, that's right.
T: We've come to see how you're doing.
[*I stood beside the therapist with the camera in my hands at this point; the therapist confirmed later that her use of "we" here refers to her and me.*]
P: Okay.
T: Well . . . Let's see. . . . Perhaps we should sit down and talk a little first?

The therapist looks around and into the living room. The wife reaches out for a walking frame with wheels that is standing nearby and turns to the patient and says, "Okay, take this . . . this walker." At the same time, the patient, *without* the walking frame, begins to move into the living room, an extension of the hallway. The therapist walks a few meters behind him, keeping her back to the wife who is left standing with the walking frame in her hands at the entrance to the living room. The following conversation takes place:

T: I see you can do without it. That's fine. You're steady on your feet.
P: I'm a little hunched over to one side.
T: Can you walk back to me so I can look at your gait right away?

The patient looks at the therapist as he turns and walks toward her (3-4 meters). The therapist watches how the patient walks, his gaze fixed on a spot on the wall just behind her. He stops right in front of her (less than a meter away) and the two establish eye contact.

T: Well, you may be a little hunched over to one side, but I don't know how you were before.
P: It's happened to me before, you see . . . several times.

During the course of the two last statements the wife walks past the two and sits down on the sofa on the far side of the living room (10 meters away). Neither therapist nor patient show any sign of noticing that she moved. Their bodies remain oriented toward each other.

T: You know, I think we should sit at the dining room table. It would be easier for me to take notes and so on.

The therapist turns toward the dining table, which is about two meters away from her and the patient (to the side, i.e., not in the direction of the wife). The two move toward two different chairs at approximately the same pace. They sit down, looking at each other as they do so. The therapist proceeds to take paper and a pen out of her bag.

A partition separates the dining room from the rest of the living room, and the patient sits down with his back to his wife, almost hidden from her behind the partition. The therapist sits at an angle across from the wife, meaning she can look at the wife if she wants to; the wife is turned toward the therapist. The therapist leans forward slightly and turns her head toward the wife, saying:

P: It's your husband I'm going to talk with. I may need to talk a little with you as well. We must all work together, right?

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The therapist smiles and gives a little laugh as she poses the question. The wife does not respond, and the patient's body remains oriented toward the therapist. The therapist once again orients her body toward the patient. The therapist seems to have taken the lead, defining the situation as a professional one.

The patient ignores his wife's urging to use the walking frame. The therapist's attention is directed toward the man, and she makes a comment, acknowledging that he walks well and can get along without any technical aids. In other words, both of them "ignore" the wife's words. The two relate to each other—by word and by body—thereby "ignoring" her with their bodies as well. The wife allows herself to be ignored.

The therapist also makes it clear in terms of her physical and verbal actions that the man of the house is her primary subject. She chooses her seat so the two can sit close together, far from the lady of the house. Thus the stage is set for concentrated interaction between the man and the therapist. The therapist explicitly also states that the patient is the one she is going to be talking with. Thus the verbal and bodily messages coincide, providing mutual reinforcement. At the same time the therapist turns to the wife, commenting that they will be working together, too, but not giving the wife a chance to take part in this particular cooperative effort.

The introductory sequence sets the tone for the meeting. As the situation progresses, the wife makes repeated attempts at inclusion, mainly verbal. She is, however, relegated to being a reluctant outsider and observer, except, where in a few situations, she is included in matters of common interest, only to be excluded again afterwards.

*History-Taking*

The therapist's and patient's bodies are oriented toward each other. The wife (W) sits on the sofa at the other end of the room, watching them. The conversation begins:

T: Let's see . . . it was the home nurse who contacted me.
P: Yes.
T: And said that you had suffered what she called a mild stroke.
P: That's right . . . a sloke.
W: *Stroke.*
T: We call it a *stroke.*
P: It happened the night before the . . .
W: Fourteenth.
P: Wednesday . . . right?
W: the *fourteenth.*
T: Yes, the thirteenth of March is what I've been given as the approximate date.
P: I couldn't get out of bed then.
T: You couldn't get out of bed.
P: And . . . afterwards I had very violent . . .
T: So you've made a fairly rapid recovery.
P: Yes.
T: That's nice.

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P: I didn't have any pain . . . just this business of being kind of hunched over to one side. And I've been bothered by that before. It disappeared after a while. I didn't have the problem before I got sick.
T: You didn't have the problem before you got sick. Had you ever experienced anything like it before?
P: First of all, I had a heart attack.

The therapist continues to present herself as a professional; she controls the conversation. The wife's contributions *correct* and *supplement* the husband's statements. He hardly seems to notice her interjections—either physically or verbally.

In the following conversation segment the therapist continues to focus her attention on the man through her bodily orientation. She uses *words* to indicate that she has heard what the wife says and makes repair work; she repeats the wife's words when she addresses herself to the husband, she modifies the wife's supplementary comments, or she does not indicate any reaction at all to one of the wife's corrections.

*The Conversation Continues*

The therapist and patient remain oriented toward each other; the wife stays on the sofa. The therapist leans toward the patient now and again; he sits calmly in the chair. She jots down notes occasionally, but not until they have been talking for a while.

The man's medical history is now being reviewed, as well as his need for help. The following has been excerpted from the conversation:

T: Did you need any home nursing help before this happened in March?
P: No.
T: You felt pretty good, did you?
P: I had a little trouble walking.
T: You had a little trouble walking . . . okay. Were you unsteady?
P: Unsteady, yeah. It was hard to get my legs to work then . . . it was . . .
W: He *shuffles*.
T: Your wife says you shuffle.
P: Yes, shuffle a little.
T: Have you used a cane?
P: Cane, yes.
T: I'm going to jot down some notes as we talk.

The conversation continues as the wife recounts that her husband also suffered a stroke three years ago and that he had trouble then with his right hand. The therapist does not look in the wife's direction, but she takes notes.

T: Can you manage most things on your own now?
P: I'm much better.
T: Do you think you've made a fast recovery?
W: You have to *tell her* it affects your bladder.
T: Your wife says you have some bladder trouble.
P: Yes, I do.
T: You didn't have trouble before?
P: I may have to answer yes to that.
W: Only a *little* before.

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T: Have you experienced any prostate problems or. . . ?
P: Nooo. . . .
T: You can't say for sure, at least. . . . But this bladder trouble has become worse since your stroke. Has it really become a problem since your stroke?
W: He was *never* wet at night before.
T: It's not uncommon to experience problems after a mild stroke. It may get better again.
P: Yes, I think so, . . . I suppose so.
T: But that's something the home nurse is helping you with now, right?
P: Yes.
T: You get in and out of bed morning and evening, then they come and help you in the bathroom . . . and so on . . . in the morning?
P: They come by morning and evening and put on one of those . . .
W: *Uridome.*[6]
P: Yes, they help you with the uridome, but you can handle the rest yourself? You can wash yourself and perform your toilet?
W: He has to have help with *everything.*
P: She's sort of taken charge in a way.
T: She has taken charge in the bathroom [*T smiles a little*].
P: Yes she has.
T: So when she comes in the morning she is here when you are performing your morning routine in the bathroom.
P: She *helps* me in the bathroom.
T: Okay, I understand.
W: Helps with the uridome.
P: She helps me with the equipment.
T: Yes, that gets to be a little extra, doesn't it.
P: Yes, and then I get up . . . it . . . sort of . . . uridome, yeah, I don't wear it at night.
T: No, you just use it during the day.
P: So I get a . . . what do you call it? [*The patient leans forward and looks in his wife's direction*]
W: Diaper.
T: It's probably a good idea to go to the toilet regularly . . . to empty your bladder regularly.
W: He does.
P: I try to do that automatically.
T: Maybe you could establish a pattern so you can eventually stop having to use a diaper too.

The conversation continues on this subject for a little longer without any comments from the wife. The therapist goes on to ask the questions, and primarily she determines the subjects they talk about. But the subjects themselves are mainly brought up by the wife. And the topics are embarrassing: she paints a picture of her husband as being quite helpless. Her contribution is to supply information about what does not work. With few exceptions she refers to her husband in the third person ("he"), looking at the therapist as she attempts to take part in the conversation.

The therapist, as before, does not include the wife in the conversation, but acknowledges her words and repeats them in different ways in further conversation with the patient. The therapist and the man stay in contact and relate to each other

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all the time—by word and body. She encourages him to talk and assures him that his functional problems are commonplace. He uses rather formal modes of expression, avoiding having to specify what he can *not* manage (e.g., "She helps me in the bathroom . . . with the equipment").

*Functional Assessment of the Patient in Sitting and Standing Positions*

The therapist stands up and asks the patient to move his chair a little. She helps him do so, moving her own chair forward so the chairs face each other with a few meters of open space around each one. The wife remains sitting on the sofa with a good view of them both; the man has his back to her, and while the therapist is facing the patient, she is also directly facing the wife.

The therapist instructs the patient to perform simple movements and routine activities.[7] She comments on and evaluates them (e.g. "You're doing fine"), or she asks his opinion (e.g., "Is it easier to do it on the one leg than on the other?"). The wife also comments on certain movements. Her remarks tend to correct or judge his movements, but the patient does not appear to be affected by them. The therapist's reactions vary, as we shall see in the next excerpt.

While the therapist tests the patient's stability and balance, he gradually hunches toward the right. Then this episode takes place:

T: It doesn't look like you've lost much strength.
P: No.
T: No it doesn't . . . but this business of standing up straight. Can you feel . . . that you are bending over to one side?
P: Yes, I feel it. [*The therapist now places her hands on the sides of his chest and slowly draws him a little more to the right, then into an upright position.*] I had this problem last summer once . . . but it disappeared after just a few days.
T: Perhaps you got a little more hunched later?
[*The therapist now takes her hands off the patient and turns toward the wife.*]
T: Was he bent to one side like this last summer too?
[*The wife gets up in response to this inquiry and comes towards them. She stops two to three meters from them as the therapist puts her hands on the patient's shoulders, addressing herself to him.*]
T: I'm asking your wife for her opinion.
W: When he had been walking for a while he leaned over and a little backwards. [*The wife demonstrates with her own body, leaning slightly to the right and backwards.*]
P: Especially if I had been walking quite a distance.
T: So you had a tendency to tilt backwards.
W: And to the right.

As this episode begins the therapist is standing close to the patient, acknowledging the patient's bent position physically, such as by putting her hands on his chest, as well as verbally. The two maintain constant eye contact. The therapist, however, then makes a direct inquiry of the wife (for the second time in the conversation so far). She does this both by turning around and by asking for the wife's observations. In "response," the wife gets up and comes over toward them, but patient and therapist continue to relate to each other. The therapist makes it

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clear, both verbally and physically, that the husband is her main focus; she *tells* him that she is asking his wife, she *places* her hands on his shoulders as the wife gets within talking distance, and she merely casts a *glance* at the wife, who talks and demonstrates, then *turns back* around before the wife is finished. Immediately afterwards the patient makes a comment, the therapist answers him, and the wife supplements the therapist's statement. The patient neither looks at nor talks to his wife, but it is obvious that he hears what she says; they are one another's audience.

*The Functional Examination Continues*

The therapist asks the patient several times to stand and lift one leg at a time. She takes the initiative for them to hold each other's hands while he follows her directions. The patient clearly has problems maintaining his balance when standing on his left leg. After a few attempts the two remain standing, looking at each other, while they continue to hold each other's hands.

W: The problem is his *coordination.*
T: Okay . . . hmmm . . . do you feel you have good . . . good *contact* with things you hold in your hands?
P: Yes.
T: Yes?
P: Yes.
T: Okay . . . when it comes to holding things and so on . . . you don't have trouble with things slipping out of your hands?
[*Therapist and patient are still holding each other's hands, and she now begins to move her hands in his.*]
P: No.
T: No.
W: You knock over glasses and things, you know.
T: Your wife thinks you have trouble knocking over glasses. . . . That may happen now right afterwards. Your movements may be a little . . .
P: I don't recall knocking over any glasses.
T: It happens to all of us [*The therapist laughs a little, dropping the patient's hands as she turns towards the wife*].
W: Can't you *remember?*
T: It doesn't matter. . . . Let's look at that walker you have there. We need to borrow it.

The therapist looks at the man, walks out of the living room and gets the walking frame that had been left standing there. This marks the beginning of the evaluation of his gait and his need for technical aids.

The wife says that "the problem is his coordination," and the therapist follows up that statement by asking several questions.[8] The patient's answer remains the same; he experiences no problems estimating distances, feeling contact, and controlling his movements. In the segment that follows, husband and wife present different versions; she says he knocks things over, he denies it. The therapist reverts to strategies used earlier: she repeats the wife's words when speaking directly to the patient or she modifies them or generalizes the entire matter (e.g., "It happens to all of us"). But the wife does not let well enough alone. She says conde-

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scendingly, "Can't you remember?" The therapist tries to downplay the importance of what the wife says (e.g., "It doesn't matter") and moves on to something else.

The therapist acknowledges the man's statement and indicates that she believes what he says. This is expressed both by what she does and what she does not do. Even though the wife says her husband "knocks over glasses and things," the therapist does not test his sensory perception when he says the opposite. This does not mean, however, that she belittles the functional problems. She comments on her observations, without beating around the bush, for instance, when she says "You're not quite as steady there." The patient has no trouble answering in such situations, appearing not to find it difficult to respond.

*Functional Assessment of the Patient's Gait and Use of Technical Aids*

The therapist observes the patient walking with the walking frame and with a cane. She evaluates the height adjustment of both aids and notes how the patient uses them. The wife now takes the initiative to join the conversation and to tell the man how he should walk. The therapist to some extent includes the wife in the conversation so that all three parties take part at times. Husband and wife, however, still address themselves to the therapist separately, hardly speaking to each other except through the therapist.

This sequence begins with the therapist placing the walking frame in front of the patient. He begins to walk and she follows him slowly, while the wife begins to talk to her about him. The patient stops and turns around so that he faces both of them (they are a little more than one meter away, standing on opposite sides of him). The wife then demonstrates how she thinks he should walk:

W: I said you should always *bend* your knees when you walk forward so you lift your hips up.

She puts her hands to her groin and, standing in place, raises one leg at a time, looking alternatively at her husband and the therapist. He stands with his hands on the walking frame and glances down and then at his wife, but mostly looks at the therapist. The therapist's eyes shift from one to the other.

T: Hmmm.
W: You see, I was once a gymnastics teacher so I . . . [*The wife giggles slightly and the therapist smiles*].
T: Is that *right*, you're a gymnastics teacher?
W: About a hundred years ago. I haven't any experience and I don't know anything about all these newfangled things.
T: Yes, but . . . many things that are . . . many of the things you have learned are fundamental. I'm sure of it.
P: She keeps trying to practice on me.
T: Having a gymnastics teacher in the house is quite an advantage.
P: Yes.
T: Okay then, I understand it's easier to stand straight when you walk with this, but I don't think it's anything to count on in the *long term*.
P and W: No, no.
W: *No* . . . and he gets out a little now.
T: Yes.

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W: I thought maybe . . . I don't think it's right that. . . . [*The wife moves toward the walking frame, positions herself in it, stretches her upper body forwards and begins to walk.*] The most important thing is to push it . . . that he sort of . . . *there* . . . that he walks like this. . . . I've been trying to do that.

The wife now walks over to assume a new role. Thus far she has mainly stood on the sidelines, correcting and supplementing the patient's verbal information. Now she represents herself as someone with a certain amount of expertise who knows the answer to the problems. The therapist's way of handling the situation is to acknowledge the wife's expertise to some extent.

*The Walking Scene Continues*

The therapist now walks behind the wife, who stops. The therapist takes the walking frame and turns halfway toward both of them.

T: As you can see, this is much too high for him. That's why he can't get into it properly. If he wants to use it, we'll have to adjust it a little. [*The therapist glances at the wife.*]

W: He could bend his elbows.

T: The point of using this is to stretch out, just as you said. [*The therapist straightens her arms and back, demonstrating how to use the walking frame.*]

W: Well, I've never had anything to do with one of these things before, I just mean . . .

T: No, I think it should be adjusted a bit lower for you, Mr. Hansen. Then . . . [*She looks at the man while adjusting the height. The three are now standing more or less in a triangle*] your arms should be almost straight on this thing, you see. . . . Let's see if I can get this loose, now it's moving down.
[*The therapist fumbles a little with the adjustment, leaning over the walking frame. The man watches the therapist, who looks up at him while she continues to adjust the apparatus*]

T: We can try it a little lower and see what you think.

W: You know, gymnastics and all that, it isn't natural . . . what is natural can really be wrong there.

The therapist has to work at the adjustment, which takes time. The wife comments that the walking frame is old and that they assembled it themselves, and the therapist looks up at her and smiles. Then the therapist places the walking frame in front of the patient, who puts his hands on it, checks to see that the height is right and puts his weight on it. The patient begins to walk away from the therapist and wife. He straightens his arms and stretches his body out. The two women follow the man with their eyes, and the sequence concludes as follows:

W: That's *much* better.

T: It's the right height now.

W: I was curious to see . . . if I was right about this today [*laughs a little*].

T: Were you?

W: Yes, I was right. I don't know anything about that thing, but I thought it had to be right.

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T: It's to help getting balance and maybe straighten up a bit. But I also think it's important for you to walk without the walking frame a little. Do you have a cane in the house? [*The wife goes out and gets a cane.*]

The therapist gives the wife a little more latitude for presenting herself and her views; the two converse more than in the other sequences. There are now three parties involved in the conversation, but the three hardly talk to one another. Again, the wife repeatedly takes the initiative to participate in the conversation, the therapist decides whether to follow up on the wife's topics and when they should be dropped, and she remains oriented mainly to the husband. As before, the patient is oriented verbally and bodily to the therapist.

The wife is now concerned about whether the patient moves in a way she considers "right," and about whether she is "right." She ascribes a role to herself that is usually reserved for superiors: she is a "judge" and problem-solver.

Communications between husband and wife indicate that there is a power struggle in progress, namely, about who is ultimately going to decide how he will walk. The therapist says that while the wife's views are to some extent valid, her husband's preferred gait may have something to do with the fact that the walking frame is not correctly adjusted, so the wife may have mistakenly estimated its height. She asks him directly what he thinks about it. The wife feels she has "walked off with the victory." The therapist's "countermove" is to reduce the wife's "victory" by directing her statements to the husband and establishing herself as the expert, the one who has the last word.

*Evaluation of Bathroom and Bedroom*

In the next two sequences, the interaction and the distribution of roles among the three participants follows the same general pattern as during the rest of the meeting. In short, throughout the next two sequences the therapist continues to focus on the man, and he continues to ignore his wife's presence. The wife stays more in the background now, both physically and in the conversation.

Both sequences begin with the therapist, by word and by body, encouraging the man to take the lead; she asks whether *he* can show *her* the bathroom and then the bedroom. Physically, she emphasizes this by remaining standing while he begins to move, and by following him at his pace. She does not look in the direction of the wife; the wife stands and waits, then walks back to the therapist.

In these two sequences it is evident how the physical space governs the therapist's attention. As she examines the bathroom and bedroom, she asks questions about supports, the height of the toilet, the use of bathtub and bed; in short, about the opportunities and requirements for movement that the rooms offer the patient and how he manages his daily routines. The shape of the rooms helps determine how the three stand in relation to one another. The bathroom, for example, is small, so if the wife were to follow the therapist into the bathroom, they would have to stand very close together. The hallway is narrow, so if the wife were to stand beside the husband, there would be very little space between them. Although they all enter the bedroom, their spatial orientation is such that the man and the therapist find it easy to establish contact. The previously described pattern of interaction and role distribution appears to have been reinforced by the physical environment.

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*Concluding Conversation, Summary, and Goodbye*

As in the beginning, the therapist now takes the initiative to ensure that she and the patient sit at the dining table. The wife is back on the sofa. During this final conversation, she is included to some extent, but both the therapist and the patient still curb her participation. Toward the end of the visit, a conversation develops between the therapist and the wife. The wife says that she has to have some minor surgery, and the two talk about being in the hospital and the practical details that need taken care of. Now the therapist speaks directly to the woman and partially turns toward her, although she glances at the man occasionally. He makes a couple of relevant comments, which he directs toward her.

The therapist brings the topic to a close, and she concludes by turning to the patient and summing up what she sees as his problem. She suggests he needs physiotherapy (practicing stability, balance, and walking). In addition, she says she thinks he should have some sort of support in the bathtub to make it easier for him to bathe. (She can get one for him, she tells him, but leaves the decision up to him.) The wife's supplementary information is not mentioned in the therapist's summary or her proposal for treatment. She asks the man's opinion of her proposal, but does not ask his wife. The wife says nothing.

The therapist gets up, the man gets up, they say goodbye and shake hands as the wife approaches them. Then the therapist turns to the wife and they say goodbye by shaking hands. The wife is rather quiet as she sees the therapist out, and is generally not nearly as assertive as she was at the beginning of the meeting.

## Discussion

*A Professional Context in a Home*

In Norway, physiotherapy home visits are not defined as treatments. Thus it is not initially necessary to involve a physician. In this case, the home nurse had contacted the physiotherapist after having gathered relevant information. The purpose of the therapist's visit was to obtain information about the patient's functional capacity in order to form an opinion regarding his treatment regime, and events that unfolded during the encounter must be seen in light of this purpose. From the outset, the therapist's attention focused on practical and social conditions and on how the patient functions in his everyday situation. His day-to-day life was the focal point, and the therapist collected information that would have been difficult to elicit had the patient visited her.

My focus has been on the local context, recognizing that situations offer a set of contingencies and constraints that may play a part in defining them, and which may not merely be created by the definition process. As Goffman stresses, such situation-specific elements are something participants "arrive" at, rather than merely construct. In this encounter, the participants find themselves in a home, the home of the married couple. This particular social setting both constrains and enables events then and there, with regard to content, context, participation, and role distribution between the parties involved.

The home arena calls for guests and hosts to switch roles. While the presence of health professionals is common in all health care institutions, in people's homes

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they are "strangers." The therapist becomes the guest who has been invited into the patient's world. The venue serves as a constant reminder of what is relevant and important: "the point at issue." It is noteworthy that in setting the stage for the meeting the home arena facilitates the activation of general social skills more profoundly than does the clinic.

None of the participants mistake the event for a social call, and the therapist takes the lead immediately and establishes the ground rules for the substance and course of the encounter. Her self-presentation is unambiguous: she poses the questions, and comments and evaluates what the patient says and does. She sums up and defines his functional problems and proposes treatment. She also decides whether or not to include his wife.

The therapist exercises her professional control to enfranchise the patient, to make him an active participant throughout the meeting, *and* to limit the wife's participation. She regulates the interaction throughout, also in areas not directly related to her professional duties (e.g., choice of seat during the conversation with the patient and having him show her around the house). She balances her contact between the husband and the wife, examining and talking with him and talking with her: two activities that entail different and often conflicting demands and expectations.

*Common Problems, Different Projects*

The man's functional problems and need for help to perform his daily routines have direct consequences for his wife and influence their lives together. It is important to both that he be properly examined and that someone understand his problems so that treatment can be initiated. This is a problem they *share*. At the same time they seem to be involved in different projects during the physiotherapist's visit. The patient is trying to manifest himself as an independent person capable of telling about himself and his problems; he downplays his helplessness and role as a patient. He "speaks" with the "voice" of an adult, a man. His wife is concerned to "get everything out in the open," she corrects and supplements his statements, answers on his behalf, and evaluates his physical performance. In other words, she dons the role of his superior, like an adult dealing with a child. It is obvious that her presentation is in conflict with the way he wants to present himself. His self-respect is at stake.

The man and the woman do not come to this interaction anew. They have been married for several decades. Whether their interactional pattern is specific for the occasion or part of a long-standing interactional ploy, we do not know. It is, however, not farfetched to assume the latter possibility since their pattern of interaction is so consistent throughout the encounter, and the couple show no signs of surprise during it.

In the course of the meeting the therapist learns that the man previously held a prominent position in the military. Although the woman was trained in some sort of gymnastics, she had not had much experience and had mainly been a housewife and homemaker. Their professional backgrounds shed some light on the power struggle that takes place between them during the meeting.

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*Conversation: Negotiations*

The man is concerned about his walking problems. He presents them first, and he repeats them. Other problems are brought up through the wife and through answers to questions posed directly by the therapist.

The wife confirms the husband's information about his problem with walking, then takes the initiative to inform the therapist about several other problems. The man is presented as being quite helpless; he has lost control of his bladder, needs help to perform most personal care and hygiene, has coordination problems, loses things and knocks them over, and is forgetful. She corrects him when he mispronounces words, and does not hesitate to complete his sentences when he takes a breather or does not immediately find the word he wants. Thus she makes it plain that he experiences trouble with his speech and memory.

During the examination, the therapist follows up on the man's version of the main problem. She attaches importance first and foremost to the information she receives from him. She emphasizes the tasks he manages to do successfully and generally downplays his problems. She only partially answers the wife's leads, and she is very cautious about asking the wife's opinion. The walking sequence is the only part of the examination during which the therapist also talks to the wife and to some extent includes her.

In light of the conversation alone, it might be said that the therapist focuses on her patient throughout the entire meeting; she enfranchises him. She also assigns the wife a role that entitles her to express an opinion, but makes her a peripheral participant. The therapist reserves the right to decide when to take account of the wife's contributions.

The man of the house portrays himself as someone who can manage without help. Throughout the encounter the wife attempts to be an active participant and contributor by introducing information as well as by correcting and evaluating her husband's statements and functions. In a way, she makes herself his superior. But the other two never confirm her attempts.

*Examination: Bodily Interaction and Roles*

The clinical examination is marked by a high degree of equality between patient and therapist. The patient is dressed and physically active throughout, he is never asked to assume a prone position, and the therapist does not resort to much touching, bodily contact, or manipulation during her examination. On these counts, this examination differs from many others. Thus the patient has greater control over the situation, appearing more as a social interlocutor. Moreover, he is asked to perform ordinary tasks, that is, movements with which he is familiar. Thus he is not confronted with the contradictory demands of being a person as well as an object, of being involved yet uninvolved, an essential part of most ordinary physical examinations (Emerson 1970; Frankel 1983; Heath 1986). The patient is not required to overlook the actions of the therapist in order for her to accomplish her job. On the contrary, he is encouraged to follow along and participate throughout the course of the entire examination.

Inherent in this diagnostic approach is a message of equality and symmetry that is reinforced by the therapist's way of conducting the examination. The movements

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of the two parties are often synchronized. When the patient walks about or sits, the therapist often does the same, and the therapist adapts to his pace. They are almost always at the same level and they are in close physical proximity during the encounter. The alignment of their gazes is coupled with postural orientation, so there are no signs of the unfocused attention and middle-stance gaze that are typical of ordinary physical examinations. And when the therapist uses her hands it is not to help the man to move or shift in position; she gives him a chance to demonstrate that he can manage on his own. She uses her hands partly to provide some support, partly to help him be bodily aware, and partly to establish contact with him.

In regard to bodily orientation and the use of space in relation to the clinical examination, the therapist focuses her attention on the patient, while keeping his wife at a distance. While observing the patient's gait and use of aids, the whole living room is used and the three share the available space, although the therapist and the man remain bodily oriented to each other most of the time. In regard to movements between the rooms and the activities that take place, physical limitations play a part as does the therapist's regulation of the interaction between the three. The therapist gives the man the chance to literally be in charge. The same applies to the events that take place when they examine the other two rooms. The wife accepts this by staying in the background, though she still attempts to intervene verbally. All in all, the patient and the therapist make up a pair, by being mutually involved in a common task that is the focus of their attention. They also collaborate in regulating the wife's participation, although this "task" is mainly controlled by the therapist.

*Together and Apart: Regulating Availability*

The communicative strategies used by each participant are generally different. The patient's pattern is consistent throughout. He tries to ignore his wife, and demonstrates this verbally and bodily. With few exceptions, he does not address himself to her. Although he looks in her direction when he asks the questions, he remains bodily oriented to the therapist.

The wife focuses all her attention on the interaction between her husband and the therapist. Almost without exception she tries to be included in the encounter by using many verbal initiatives. During the conversation her words and body are usually oriented to the therapist. For instance, she refers to her husband as "he" except for a few times when she criticizes him directly.

Husband and wife maintain a distance between them, and each seeks contact with the therapist, using both verbal and physical means. In any event they have more verbal than bodily contact, although their verbal interaction is also extremely limited.

The therapist's way of relating to the wife and of regulating her participation varies somewhat. In addition to the therapist deciding whether or not to include the wife, another pattern emerges. The therapist's invitations are mainly verbal, while her closings are almost always physical. She invariably has more contact with the wife by words than by actions. The therapist remains bodily oriented to the patient even when she is talking with his wife. She turns toward him as she talks to his wife and she looks at him while she and the wife are talking, but never the other way round.

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To sum up, words and body are here used to regulate contact, roles, and relationships. With their bodies, both patient and therapist concurrently separate themselves from the wife, regulate the distance between themselves and her, and develop cooperation and closeness with each other.

*Managing the Undisclosed*

Since the man's functional problems affect the couple's everyday lives, it is thought-provoking to see how consistently the wife's participation is limited throughout this meeting. The same applies to the fact that the therapist never appeals to husband and wife to work together.

It is relevant to question whether the patient perceives his functional problems as something that makes him inferior, whether he wants to hide them, and the extent to which they interfere with his life activities and social interaction.

The man presents the problems he has with his gait, problems that are readily visible to all. Since he is old, one might expect that he accepts balance problems and perhaps even the need for some technical aids. However, as a shut-in, dependent on his wife, and being unable to go out when he wants to without someone to assist him, his self-esteem may be threatened. Because the ability to go out involves independence and social mobility, his preoccupation with his gait makes sense. His failure to tell the therapist about other problems may be interpreted to mean that he did not consider them as important as his gait problems, and (or) that he considered them embarrassing.

Goffman distinguishes between being "discredited" and "discreditable" conditions. The former refers to stigmas that are visible to all. The latter refer to "differentnesses" that are not immediately apparent and are not common prior knowledge. The point at issue with discreditable persons is "that of managing information about the failing. To display, or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when and where" (1968:57). The problem is one of managing *undisclosed* information. Covering (and cowering) are thus interactional adaptive strategies employed in order to, as Goffman puts it, "pass" as normal.

In response to his wife's attempts to supply information about him, the husband sometimes supplements her statements (bladder) and sometimes ignores her or denies what she says (having poor coordination, knocking over glasses). While talking to the therapist he sometimes "glosses over" a little, denying two conditions (speech problems and poor coordination). Despite the therapist's acceptance and the good contact they establish, he does not put all his cards on the table. This indicates that he feels the problems being discussed are embarrassing and degrading.

Having speech and memory problems, losing things, and knocking things over can complicate social interaction. Any lack of body control poses a general threat to one's status as an adult. Yet these dysfunctions, as opposed to incontinence, the use of uridomes and diapers, and an inability to see to one's own personal hygiene, are difficult to hide. No one could know about those problems unless they lived with him. But his wife talks about these things as well. They indicate that he needs help and is dependent on others. Precisely this type of problem can be extremely degrading for a male adult, who is mortified by learning that others

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know about it. It is reasonable to assume that this attitude is reinforced by his professional background.

From the wife's perspective, it is important that the therapist be given a realistic picture of her husband's functional problems. However, she shows little tact, empathy, or respect for his self-esteem and intimacy limits. She discloses information and "reveals" his weaknesses, his differentness.

The near absence of any verbal response by the husband to his wife, the way the husband's gaze and bodily orientation are directed elsewhere, even when she talks to him and about him, may be interpreted as an expression of his disapproval of her contribution and of his wish to be able to present himself without help. The therapist's consistent, accepting attitude toward the man, combined with her strategies to keep the wife at a distance, must be seen in this light. The wife's contributions, as well as the husband's reactions to them, motivates a pattern of communication on the therapist's part that serves to confirm the husband's presentation of self and his sense of self, helping him to save face. Together, the therapist and the man dampen the wife's involvement, thus preventing further disclosure of embarrassing details.

*Whose Perspective?*

In one respect, the encounter has much in common with the dominant pattern found in medical settings: the therapist controls almost every aspect of the encounter's shape, sequence, and timing, and the talk is dominated by a question-and-answer pattern in which she is the questioner. It is well documented that such medical control is systematic, all-pervasive, and almost unquestioned (Beckman and Frankel 1984; Byrne and Long 1984; Frankel 1990; Mishler 1984; West 1989). But the encounter differs significantly from the norm in several other respects. First of all, the *way* the therapist exercises professional control does not add to the dominant pattern. She offers the patient opportunities to present his version. She demonstrates an attentive attitude toward him, never overlooks his contributions, and actively seeks out his thoughts and opinions. Moreover, while it is documented that the talk in medical encounters is almost exclusively confined to medical matters, the focus of concern in this encounter is the patient's daily life and functions. In addition, a language is employed that largely precludes the use of medical and technical terms. To an extent, patient and therapist build on each other's experience and knowledge. Thus the encounter diverges in a number of ways from most clinical encounters as they have been documented; it can hardly be described as being dominated by the professional perspective. In Mishler's terms (1984), the "voice of the lifeworld" is salient in this encounter.[9]

Regarding the relationship between therapist and wife, the therapist is selective about the information she accepts from the wife and she partly violates common codes regarding attention cues. This communicative pattern between therapist and wife is quite similar to the one that dominates the relationship between doctor and patient in two-party medical encounters. Studies of interaction in clinical encounters involving three parties in which the patient is a child and one of the parents participates show that the patient is often excluded from the interaction with the physician. The physician spends little time talking with the patient (child) or with the child and parent together (Aronssen 1988; Strong 1979). The triadic discourse

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becomes dyadic, and the parent takes over the role of patient in the discourse. Strong showed also that parents are at the physicians' disposal; they are partly excluded and controlled. Although they might be partners, they are not equals, and the power imbalance is striking. Although Strong's data relate solely to children's clinics, he argues that there are good reasons for suggesting that medical control is a widespread phenomenon in all kinds of medical encounters, and that physicians attempt to control interactions even with articulate and adult persons.

In the present encounter, the patient is an adult, an old man who has lost some body control. When his wife "reveals" his dysfunctions and is active on his behalf, his status as an adult man is particularly at stake. That the therapist does not engage herself in much talk with the wife, and does not relate to the patient as a "child," but keeps her main involvement with the husband and relates to him as a responsible and reasonable adult, is thus an interesting feature.[10]

The comparison should not be taken too far, however, since there are obvious differences between encounters with children and adults. Children, unlike adults, are incapable of presenting their problems in a precise manner, and cannot be regarded as being responsible for their own health. As we have seen, the therapist relates to the husband as an adult from the onset; doubtless because that is what he is. His wife is responsible neither for his presentation nor for his health. Traditional Norwegian ideas of family life, however, entail a division of labor between men and women in which women are linked to nourishing and caring, and to helping those who need it, especially their own family members, particularly their children and husband. The woman in question has been a housewife for years and she has lived up to local expectations about women. Against this background the therapist's practice must be seen as particularly underscoring the man's autonomy and of his self-respect. It is illuminating that the man showed bathroom and bedroom to the therapist, but not the kitchen. As a man formerly of some importance, he obviously regarded this room as irrelevant, and believed that the kitchen had nothing to do with his functional capacity. The therapist simply "accepted" this; she made no communicative move in this regard. I commented upon this "natural" division of work between husband and wife afterwards. The therapist considered her own (and the husband's) behavior so self-evident (and my question so uninteresting) that it was obviously not worth talking about.

There are obvious differences between physicians and physiotherapists concerning their formal responsibility. Physiotherapists are not at the apex of a hierarchical structure in which information goes "up" and orders go "down." Their status is "in between" and, to patients, less intimidating. Even when therapists professionally control a situation, this control is of a softer kind and is perceived by patients to offer them more latitude, and encourage them to voice their concerns. The present encounter has features in common with documented encounters in medical settings that show that institutionally based authority in medicine, too, can be used to empower patients to present their versions, and include more than strictly medical matters (Clark and Mishler 1992; Tannen and Wallat 1987).

The visiting therapists (all women) in this study said that they found it challenging and valuable to work in homes, and expressed concern for elderly people's self-respect. These findings contrast with those of a study based on medical encounters in homes (Sankar 1988), which reported that for medical students loss of control was the main and overshadowing problem. Although the two studies

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cannot be directly compared, their differences bear witness to and represent central differences between the medical and the physiotherapeutic professions.

It may be asked how the presented encounter relates to other cases in my study. Only two other three-party encounters were directly comparable. In one, the communicative pattern resembles the above in that the wife stayed at the sidelines. But this was an outcome of strategies deployed by all three participants. In the other, neither therapist nor patient limited the participation of the third party, a daughter-in-law. To the contrary, they stimulated it by both verbal and bodily means. Due to the small number of cases in my study, this encounter can be said to be neither typical nor atypical. The extent to which the pattern described here is common in three-party physiotherapy encounters will not be known until more research is done.[11]

*Not Words Alone*

One of the most influential approaches to the study of doctor-patient relationships uses the concept of "explanatory models." Primarily cognitive in its orientation, this approach is concerned with people's subjective senses of sickness and health, and how they verbalize these. Biomedical practitioners usually problematize patients' explanatory models. But they believe that, through negotiation, they can work to eliminate discrepancies between patients' models and their own.

It has been pointed out that this approach has its shortcomings. First of all, a persistent concentration on meaning tends to ignore the interaction itself (Lazarus 1988). While rich cognitive and symbolic material may be provided, the emerging interaction between the participating parties (minimally two, occasionally several persons) recedes into the background. Second, proponents of this approach try to explain the meaning of informants' statements in terms of these models alone. But, as Young (1981, 1992) argues, other kinds of knowledge are involved.[12] The result of employing explanatory models may thus be to perpetuate the ontological split between communication and professional work, and between culture and nature, thereby conceptualizing clinical events as little more than "mindful" events.

In contrast, my concern is with the broader social interaction *between* the participating parties, rather than with the patient or the professional in isolation. Thus I cannot assume that patients "have" nothing but health problems and explanatory models. To confine the analysis to explanatory and cognitive aspects is to disregard the cumulative consequences of the interaction as a whole as it is organized from one moment to the next. Analytical progress rests on our ability to pay close attention to the fuller social relationships between the parties. This means first of all that we must be prepared for the possibility that while some of these relationships are "new" and ephemeral, others may have matured over decades and will continue to develop. We must also remember that the parties bring to the encounter various and unequally distributed capacities, and be attuned to how people play out power in actual situations. In short, we need to focus on negotiations between parties who personify power differentials. But to focus merely on how these negotiations are played out verbally will not suffice. I have attempted to show above how bodily postures, movements, gazes, uses of space, *and* verbal utterances are all variously resorted to as participants compete to manage an intricately unfolding social situation.

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Issues of power and control clearly represent enduring challenges in clinical work and studies of it. I support an approach to clinical encounters that takes for granted that encounters are both coconstructed by the participants and "preformed" by situational and institutional demands and circumstances. Måseide (1991), writing in this tradition, labels the approach the "control model," because it is based on the crucial recognition that unless a measure of professional control is maintained, it is difficult to imagine how competent clinical work can be accomplished at all.[13] Had the therapist lost control in the situation discussed above and "given in" to the wife's interventions, for example, she might have stimulated the wife's ("victorious") leadership and correspondingly undermined the husband's capability and self-respect. In turn, this might have left him miserable and contributed to his dependency both on his wife and on future therapists and other professionals. It is relevant in this connection to recall that independence is a virtually unquestioned ideal in Norway, as it is in other Western countries. I think, however, that it is well if researchers and health personnel alike reconsider this ideal and its normative overtones. At any rate, as this encounter illustrates, the clinicians' options for actions in real-life situations are often limited.

It has further been suggested by several social scientists that contextualization of actual observational studies is needed. This article is intended as a step in this direction. Although we must assume that communication in clinical settings is both institutionally structured and interactionally accomplished, it is not my aim to offer a comprehensive analysis of the wider cultural, political, and institutional setting within which the encounters take place. My purpose is to show that the scope for analyses, incorporating also structural aspects, is fruitfully expanded by accounting properly for the multilevelled interactions in the encounters themselves, and that by attending to verbal *and* bodily actions, the potential for an improved understanding of clinical encounters will increase. Furthermore, as I hope has become clear, I regard the physicospatial frames of clinical encounters neither as "external" to the interaction proper nor as a "static" context for it. Inspired by anthropology, I distinguish analytically between external frames such as health institutions or homes and interaction in the clinical events under study. In my view these are not environments to which individuals "adapt," but are rather (re)constructed in social action. Not only do the layout, the light, the furniture, and the overall atmosphere of arenas for clinical encounters subtly influence the "guests," they more generally inform the context and the climate for cooperation; they work, one might say, as "filters" of relevance, which determine how the parties can relate to each other and to the "socio-matter" (Osterberg 1978).

## Concluding Remarks

Sustained focus on real-life practice is as urgently needed in physiotherapy as it is in any other practical or professional activity. When analyzing clinical practice on the basis of the moment-to-moment organization of actions and interaction between participants, it becomes possible to understand how contexts are established and maintained, and what kind of cooperation is being developed. I hope to have demonstrated that when encounters are analyzed as wholes, traditional divisions between "professional" work and communication disappear. Messages are communicated through professional approaches per se, as well as through the performance of professional duties. Such messages shape the context and the

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forms of cooperation that develop. The interaction between participants determines the diagnostic information that is negotiated and constructed. Analyses such as the one above can help professionals (and researchers) realize how clinical tasks are embedded in social processes, and provide a basis for understanding how the control being exercised connects with the total context and bonds created between participants. Both are prerequisites for superseding the traditional distinction between "real" professional activity and the "social" aspects of clinical work. Further prerequisites include accounting for bodily actions in studies of the social organization of clinical encounters, and rejecting a view of the body that strips it of its social content.

## NOTES

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1. Those who adhere to this tradition are deeply concerned with the politicoeconomic relations of sickness and health care. I do not trace such relations in this article.

2. Goffman's theoretical position is under debate. The question of where his works should be placed in relation to structuralism and interactionism is beyond the scope of this article.

3. In other parts of the health services system referrals to physiotherapy must be issued by physicians and take the form of medical diagnoses.

4. Goffman defines the notion of footing as follows: "A change in footing implies a change in the alignment we take up to ourselves and others present as expressed in the way we manage the production or reception of an utterance. A change in our footing is another way of talking about a change in our frame for events" (Goffman 1981:128).

5. I have presented how the participants behave bodily in running text, while the verbal dialogue is presented conventionally, with each turn at one line. Other methods of presentation are possible, but I find this way the most readable.

6. Uridome is an external condom catheter.

7. This involves getting a general idea of the patient's strength and mobility, his stability and balance, and what he can and cannot do. She asks him to raise his arms, stand up and sit down on the chair, stand on one leg, and so on.

8. These questions may seem strange to a layperson. To a physiotherapist, however, they are relevant for a stroke victim since the stroke may cause reduced or disturbed sensory perception, including proprioception (the position of and movement in joints and muscles).

9. Mishler has introduced the concept of "voice" to describe relationships between talk and a speaker's underlying framework of meaning. His research identifies struggles and conflicts between the "voice of medicine" and the "voice of the lifeworld." The former is said to express a technical, biomedical frame of reference, while the latter expresses the patient's personal "contextually-grounded experiences of events and problems" expressed in familiar terms (1984:104). His analysis, based on interviews, shows that the "voice of medicine" usually dominated the discourse. In the present context, where "voice" is expanded to include bodily interaction, the therapist stimulates the patient's participation *through bodily interaction as well as through words.* In everyday life people meet, interpret, and make contact with one another as embodied subjects. We do so unconsciously; it is a social skill we take for granted. Thus the "voice of the lifeworld" in this encounter includes this social skill, which is first and foremost acquired through life experience.

10. In contemporary Western cultures "the child" has come, quite literally, to embody the dominant model of dependency (Hochey and James 1993). This is why I place the child between inverted commas here.

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11. The remaining 12 encounters (with only two parties present) share the feature that therapists generally convey more interest and involvement in their patients by way of their bodies than through their words (Thornquist 1991, 1994, 1995).

12. It should be added that some advocates of this approach tend to neglect that there may be a great deal of variability and lack of coherence in explanatory models—both the patients' and the professionals'. Kleinman, however, to whom the explanatory model approach must be credited, stresses that explanatory models may be fragmented, incoherent, and changing (1980).

13. This essential point is brought home well by the title of the article referred to: "Possibly abusive, often benign, always necessary. On professional power and control."

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