Demonstrative Suffering: The Gestural (Re)embodiment of Symptoms

By Christian Heath

Despite the long-standing interest in emotion and bodily conduct, there remains relatively little research concerned with how gestures are used with talk and within interaction to reveal emotional and personal experience. In this article, the author considers the medical consultation and, in particular, the ways in which patients attempt to reveal their experience of illness to the doctor. The paper examines how gesture and other forms of bodily conduct are used to transform symptoms into suffering; to display, enact, and (re)embody medical problems and difficulties. The analysis is based on videorecordings of primary health care consultations and focuses on the social and interactional organization of demonstrative suffering.

There is a long and distinguished tradition of research that explores ways in which gesture and other forms of bodily conduct express emotion and the psychological characteristics of people. Darwin's 1872 study of the expression of emotions in man and animals is critical in this regard, not so much for the uniqueness of its contribution—it reflects a growing intellectual interest in the mid-19th century with bodily expression—but rather through its methodological precepts and its profound influence on subsequent generations of research. Consider, for example, the rich and insightful studies of La Barre (1947), Ekman (1973), Ekman and Friesen (1975), and colleagues concerned with the face and the ways in which a complex array of facial configurations serve to systematically embody particular forms of expression. Such studies reflect an important body of research concerned with interpersonal communication, research that is primarily concerned with identifying how particular forms of bodily expression and conduct communicate specific emotional and psychological characteristics. The social organization of emotional expression has received less attention and, despite pioneering research on gesture in communication—for example, by Scheflen (1973), Kendon (1980, 1992), Birdwhistell (1970), and, more recently, Goodwin (1981, 2000),

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Goodwin and Goodwin (1992), Streeck (1996, 1988), LeBaron & Streeck (2000), McNeill (1985, 2000) and others, we find relatively few studies concerned with the ways in which an individual's personal experience is revealed and managed, through visual and vocal conduct, within face-to-face interaction.

In this regard, the medical consultation provides an interesting case for those with an interest in bodily expression and conduct. Patients provide doctors with a characterization of their difficulties, which often involve bodily symptoms, pain, and suffering, and not infrequently entail associated emotional and psychological problems. Although psychiatry has long provided a relevant domain for those with a professional concern with bodily and psychological suffering, surprisingly little attention has been paid to the ways in which patients give voice to their troubles and difficulties within the practical constraints on the consultation. In this light, it is pleasing to note the growing body of research concerned with doctor and patient communication (see, for example, Byrne & Long, 1976; Peräkylä, 1995; Silverman, 1997; and West, 1985), a corpus of research providing a distinctive body of findings concerning the disclosure and management of troubles within the consultation. These studies, however, are primarily concerned with the organization of talk in the consultation and pay little attention to the ways in which patients reveal their problems and difficulties through visual as well as spoken conduct. The consultation provides a unique opportunity to consider how the body is used to express symptoms and suffering, to reveal the very difficulty and illness that is embodied "within" the patient's physic.

A rather different corpus of research bears upon the issues discussed in this essay. There is a long-standing tradition of studies within medical sociology concerned with "illness behavior" (for overviews, see, for example, Mechanic, 1982; Morse & Johnson, 1991). In general these studies explore the considerations and factors that feature in a patient's (or guardian's) decision to seek professional medical help. Unfortunately, perhaps, little of this research has examined how patients communicate their difficulties to doctors within the practicalities of the consultation and in particular how they attempt to provide reasonable grounds for seeking professional medical help. Even Parsons's (1951) important and insightful schematic overview of the situation of medical practice fails to illuminate how patients gain legitimate access to the sick role through their dealings with the doctor. Yet it is within the "situation of medical practice" and in particular the consultation that patients reveal and give substance to their difficulties, and it is largely through communication between patient and doctor that diagnosis and management are accomplished. It may be the case, therefore, that in turning attention to bodily expression during the medical consultation we can begin to consider how troubles are revealed and managed.

In this article, I interweave these rather different lines of research—the organization of bodily expression with the revelation of illness within the medical consultation. The paper explores the ways in which patients present their symptoms to the doctor and in particular how they attempt to express their pain and suffering. It considers how patients create a sense of their difficulties and encourage the doctor to witness, if only momentarily, the suffering they have incurred. In addressing the character of expressive gestures within the medical consultation, the

article touches on the relationship between description and experience and considers the ways in which individuals may reveal, even rekindle, the sensation of difficulties and suffering. In this way, the article contributes to our understanding of the social and interactional organization of gesture and the interdependence of talk and bodily conduct, and it throws light upon the ways in which patients attempt to legitimize seeking professional medical help and shape diagnosis and management of a particular complaint.

The examples discussed in the paper are drawn primarily from video recordings of general practice or primary health care consultations. They have been gathered over many years as part of a series of projects concerned with various aspects of professional practice and interaction in the medical consultation (see, for example, Heath, 1986, 1989; Heath & Luff, 2000). Data gathering has also included extensive fieldwork and discussions with general practitioners and patients. In all, we have recordings of more than 2,000 consultations drawn from various practices throughout Britain and involving many different patients and practitioners. The paper begins by exploring the ways in which patients use gesture and other forms of bodily conduct, in talk, to express their symptoms and suffering. It discusses one or two instances and sketches how gesture serves to provide symptoms with distinct qualities. It then considers in detail how the expression of symptoms and suffering is delicately produced and coordinated with regard to the moment-by-moment participation of the doctor. Finally, it briefly considers the ways in which these bodily revelations feature in assessment and diagnosis. The paper therefore is designed to progressively reveal how the gestural embodiment of symptoms is embedded within the emerging interaction, negotiation, and coparticipation of patient and doctor.

Revealing Symptoms

The general practice consultation ordinarily begins with patients providing their reason for seeking medical help or updating the doctor on the progress of their illness. In either case patients present and characterize their symptoms and suffering and the doctor initiates a series of inquiries to clarify certain characteristics of the difficulty. In some, but by no means all, cases, the patients actually show the difficulty to the doctor and its visible manifestation—a boil, a bruise, a rash, or whatever—which temporarily becomes the principle focus of inquiry and investigation. More often than not, however, there is no visible manifestation of the complaint. The patient has to provide the sense and significance of the illness and its symptoms through talk and bodily conduct and thereby legitimize seeking the professional help of the doctor.

Consider the following example, drawn from the beginning of the consultation. The patient enters, sits down, and the doctor initiates the business at hand with "What can we do for you?" The fragments are transcribed using the orthography developed by Gail Jefferson (details may be found in Drew & Heritage, 1992; Sacks, 1992; and Sacks, Schegloff, & Jefferson, 1973). All transcripts have been simplified, where reasonable, to assist clarity.

terrible headaches

Figure 1.

move my eyes

Figure 2.

eyes

Figure 3.

Fragment 1.

Dr: What can we do for you?
(0.5)
P: Well all weekend I've been getting these terrible headaches<it's:: (0.2) all sort of top of me head there:: (.) an at the back (.) °hhh an when I get these headaches: if I move my eyes: from sort of side to side that (.) type of thing it really ach: (.) aches you know all (.) under me eyes: (.) °hhh on Sunday I noticed they went all puffy (0.2) an (red)

The patient's description of her problem is accompanied by a series of gestures. These gestures both locate the areas of difficulty and give a flavor of particular symptoms. The patient utters "terrible headaches" (Figure 1) and, as she describes the location of the difficulty, she places both hands on her head at a series of different locations, simulating pressure while revealing the tenderness of different areas of the head. With "move my eyes from side to side" (Figure 2), she places her hands to one side of her head and looks to and fro, revealing the exaggerated sensation of the difficulty, and with "really ach: (.) aches you know," she vibrates the fingers over the eyes, seemingly revealing aching. A few moments later, she encircles the eyes with her hands showing the extent of the redness and puffiness.

Taking just the initial sequence, we can see how the gestures serve to specify the difficulty and work to project further characterization. The initial assessment of the difficulty, "terrible headaches," forms a juncture in which the doctor might initiate a series of inquiries as to the nature of the problem. With the word "terrible," the patient turns toward the doctor and begins to raise her hands to her head; as the hands arrive, she latches "it's" and pauses. The pronoun, coupled with the arriving gesture, serves not simply to project more to follow (and secure the "floor" for the patient), but neatly links the arriving gesture retrospectively to the "terrible headaches" and prospectively to the upcoming, yet to be mentioned, characterization. Moreover, the ways in which the hands land and clasp the head, reveal visually, not only the locale of the difficulty, but also the sensitivity of the area in question. With the arriving hands, and "it's," the doctor produces a slight

reorientation and eyebrow raise, which nicely serve to acknowledge the assessment and display continued involvement in the upcoming exposition.

Despite the lack of a physical manifestation of the complaint, the patient encourages the doctor to look at the area of the difficulties. Taking the symptoms and their respective locations in turn, the patient overlays particular parts of her body with a series of gestures. The gestures give a sense of the suffering experienced by the patient. For example, it is not just a headache, but a pain that derives from localized pressure at different areas of the head, which renders it acutely sensitive. The gestures demarcate the position, the scale (for example, the broad area of puffiness), and the character of the suffering. They *enliven*, if only momentarily, different parts of the body and provide a dramatic display of the symptoms and suffering incurred by the patient. She reveals the particular qualities of the difficulties then and there to the doctor. Her subjective experience of the symptoms is overlaid, played out, across the relevant parts and surface areas of the body.

These dramatic displays of symptoms within the diagnostic phase of the consultation are not unusual. To give a flavor of the different forms of bodily expression that arise, consider the following instance. Once again, the patient suffers from a relatively innocuous complaint: a persistent sore throat and a cough. In its presentation, however, it gains a significance, an importance, that it might otherwise not have.

Fragment 2.

P: Well I've had this:: (.) sore throat on an: off for (.) weeks now
Dr: °Oh↑ dear.
P: an I've got a cough (.) but i(h)t's. i(h)t's I feel as though I'm cho:king <you know when I'm c ┌ oughing (.) I'm getting
Dr: └ mm mh
P: no relief from coughing, it's just sort of choking it's ┌ sor(t) of at the back of my throat.
Dr: └ °hhhhhh
Dr: Do you bring any phlegm up when you cough?
P: Well yesterday I managed to be sick and I did, you know but normally it
Dr: But you vomited then(it)?

As she begins to provide her reason for seeking medical help, the patient momentarily pauses, allowing her hand to stroke her throat as she first mentions her difficulty. The stroking hand demarcates the area and extent of the difficulty. With "cough," she vibrates her hand to and fro just below the mouth, and as she begins to mention choking, she grasps and pinches her throat. A few moments later, after once again simulating choking and coughing, she mentions that she managed to be sick (Figure 5). Accompanying the symptom is a gesture, which dramatically displays vomit leaving the patient's mouth with some velocity, unfortunately, perhaps, in the direction of the doctor. After grasping the throat once again with "normally," she thrusts her head forward as if choking. A moment later, he initiates the physical examination inspecting the patient's throat.

i(h)t's. i(h)t's I

Figure 4.

managed to be sick

Figure 5.

Taking just one part of the activity, we can look in a little more detail how the patient configures the symptoms. Just as the patient is about to utter "I feel as though I am cho:king," over the repetition of "i(h)t's" (Figure 4), she clutches, reclutches, and vibrates her throat; the gesture co-occurs with the repetition, and visibly and audibly invokes choking. The prospective focus of the gesture to the word "cho:king" is neatly embedded within a preturn repetition that itself embodies the upcoming characterization. With "choking," the hand falls from the throat, the doctor turns away and removes his glasses. The articulation of the word choking projects more to follow and the patient builds the continuation to repeat and further explicate the difficulty. At the tail end of "you know," she raises her hand and vibrates it, in front of her throat and before the doctor. The gesture appears to encourage the doctor to turn back toward the patient, and as his gaze arrives she reshapes the gesture. The gesture's articulation therefore prospectively animates and embodies the upcoming symptoms and is sensitive to the orientation and emerging participation of the doctor.

As with Fragment 1, the patient's gestures begin by demarcating the location of difficulty. They then overlay the relevant area and body parts with a series of gestures that visually reveal the symptoms to the doctor: the clasping hand on the throat dramatically displaying choking, the vibrating gesture near the mouth revealing the severity of the cough, and the pièce de résistance, the vomit ejected with some force from the mouth. The gestures powerfully configure not just the symptoms, but the symptoms in action, as if the patient is visibly suffering the difficulties she is presenting to the doctor. They not only serve to give a particular impression of the patient's complaint, but animate different parts of the body as if the symptoms are in dramatic operation, here and now. They attain a presence, an existence, they would not otherwise have.

The patient's gestures and bodily comportment serve to transform generic categories of complaint into unique and particular difficulties. Complaints such as sore throats, coughs, headaches, and the like, which might even be thought rather trivial, are given a certain distinctiveness and significance, characteristics that warrant medical intervention and help. They are not "any sore throat or cough," but

unique and dramatically severe difficulties, difficulties that anyone might treat as professionally relevant problems. Patients particularize their problems through the ways in which they dramatically animate their specific experience of their symptoms.

Taking the two fragments, therefore, we can begin to see how patients can render their experience of their difficulties visible within the practical constraints of the medical consultation. Through gesture and bodily conduct, patients transpose inner suffering, their personal subjective experience of their complaint, to the body's surface and particular parts and areas of their physic. The inner and the subjective are overlaid on the outer surface of the body and rendered visible and objective. Moreover, through gesture and bodily conduct patients take symptoms experienced on another occasion and transpose them to the present. They reveal their symptoms, and their experience of their symptoms, here and now, revealing the very characteristics that they have been invited to describe. To use and slightly corrupt Weider's (1974) phrase, patients render their symptoms "transituational," transposing experience and conduct from one occasion to another. The doctor momentarily becomes a spectator, witness to the symptoms that the patient has experienced (or is experiencing).

We can also begin to see how the gestures work with and within the talk, and in particular how they serve to prospectively display distinct qualities and the severity of the voiced symptom(s). The occurrence and articulation of these gestural embodiments can also be seen, in this brief sketch of the fragments, to be sensitive to, and relevant for, the participation of the doctor, and in particular the ways in which he should orient and respond to the characterization. In the following sections we wish to consider the interactional production and intelligibility of these embodiments of symptoms in a little more detail.

Opportunistic Revelations

In the cases we have discussed so far, patients, in presenting their symptoms and suffering, use various forms of bodily conduct to reveal the particular characteristics of their difficulty. These revelations serve to provide the doctor with an appreciation of the difficulty and its significance, transforming generic types of routine illness into unique and perhaps important problems. None of these cases suggest that the patient is actually experiencing his or her symptoms then and there within the medical consultation; rather the patient's gesture and bodily conduct serve to give a sense of the difficulties and suffering that the patient endures in other circumstances. On occasion, however, patients appear to experience, within the consultation, their very symptoms and attempt to exploit their momentary suffering to encourage the doctor to notice and discuss their difficulties.

However, patients who wish to exploit the momentary occurrence of a symptom face a potential problem. The occurrence of a symptom does not necessarily coincide with opportunities within the interaction with the doctor at which they have the chance to voice their symptoms. Indeed, unless the symptoms just happen to arise within a patient's turn within the diagnostic phase of the consultation,

it may prove difficult to interject the symptom into the developing course of the conversation. In this regard, it is worth mentioning a phenomenon that Byrne and Long (1976) pointed out some years ago known as the "by the way syndrome," exemplified by patients who, toward the end of consultation, try to introduce previously unmentioned difficulties and/or engender further discussion about their problems.

Consider the following fragment. We join the action toward the end of the consultation. The doctor hands a prescription to the patient, provides accompanying instructions and suggests that the patient arrange to return and see the doctor with whom he is registered. As the doctor utters "one in the morning," the patient begins to heave as he visibly takes a series of deep in-and-out breaths.

Fragment 3.

Dr: These are for you:, (.) you take one in the morning (0.6) um:: (0.2) and I'd like you to come back < I think probably better come back
D: and see Doctor Cha ⌜ mbers
P: ⌞ khhhhhhhhh hhh
Dr: see (him) in a fortnight
P: Some of that's bronchitis
P: hehe ⌜ hehehhehhehhehheh
Dr: ⌞ (there you are) °hh one lot of tablets at a time {folds paper}

By "come back" (Figure 6), the patient has clasped his chest, and as "Chambers" is uttered, the patient turns away, begins to place his hand over his mouth and produces a loud and dramatic cough (Figure 7).

Despite the patient's seeming inability to suppress the outburst, and the apparent severity of cough, it is neatly positioned to occur just at turn completion. Notwithstanding the cough's etiquette, the doctor does not respond to the symptom; he continues to look at the prescription in his hand (even as the patient's cough subsides). As the projected completion of the cough emerges, he continues with the proposed arrangements, "see him in a fortnight."

Despite the lack of response as the doctor continues to inform the patient of relevant arrangements, the patient does not abandon his attempt to topicalize the cough. With "see (him) in a fortnight," he gestures to and fro over his chest as if the difficulty continues after the completion of the cough. Following the completion of the doctor's turn, he then suggests that the cough is a symptom of bronchitis. Even before he finishes his utterance the doctor turns back to the prescription, and the patient transforms a potentially serious symptom and complaint into something to be taken lightheartedly.

The patient attempts to encourage the doctor to adopt an "investigative or diagnostic" stance toward the outburst (see Sacks, 1992; Sudnow, 1967). The cough is carefully designed to display the potential severity of the symptom, while suppressing its true or natural force. By withholding response to the outburst, and by maintaining his focal attention on the prescription, which is relevant to the topic at hand and the consultation's upcoming closure, the doctor rids the cough of its

better come back

Figure 6.

khhhhhhhhh hhh

Figure 7.

potential sequential import. "That's bronchitis" attempts to assert the diagnostic relevance of the outburst, but finding the doctor does not respond to the symptom, the patient abandons his attempt to engender a diagnostic sequence and transform the complaint into a joke.

It is perhaps relevant to note that the patient's outburst arises toward the end of a consultation in which the doctor has failed to find evidence of the patient's presenting symptoms. The cough provides the patient with an opportunity to introduce a new but related difficulty and to claim that it is evidence of underlying illness, namely bronchitis. The introduction of hitherto unmentioned symptoms toward the end of the consultation is not uncommon in cases where there is a potential incongruence between the patient's presenting complaint and the assessment of diagnosis provided by the doctor (see Heath, 1992; Peräkylä, 1998). Indeed, these postmanagement re-presentations of symptoms frequently arise in circumstances where the diagnosis or assessment does not appear to confirm the significance or severity of the problem presented by the patient earlier in the consultation. In this regard, the momentary experience of a particular symptom may provide an opportunity to reaffirm the existence and significance of the complaint, and to underscore the grounds for seeking professional medical help.

Consider the following example, drawn from a long and complicated consultation in which the patient's presenting complaint, arthritis, has become secondary to the issue as to whether the patient should be allowed to drive again following a minor stroke some time ago. We join the action as the doctor hands the patient a prescription and summarizes the treatment to help avoid any further strokes.

Fragment 4.

Dr I have given you two months supply of the tablets:
P: Thank you very much
(0.3) {patient stands}
→ P: °hhtha(h)nk y(hh)ou. Ooh::(er)
(0.3)

P: (Did you see) just when I got up.
→ P: Oo ┌ oh: there {patient restands}
Dr: └ Yeh.
P: (yeah) hehe<u>heh</u>
Dr: hehh
P: Anyway (0.3) And when I try to get in the car::::
Dr: mmh
→ P: Ooooooh::. {reenacts difficulty}
(0.2)
Dr: Yers:
P: Heh ┌ thanks very ┌ much doctor
Dr: └ Well └ bit bit of walking will do do you more good.

The patient thanks the doctor and begins to stand. The doctor is looking at the medical records on the desk. As he bends forward and begins to raise himself, the patient thanks the doctor once again. The second thank you is unlike the first. It is said with suffering "°hhtha(h)nk y(hh)ou" (Figure 9), breathy, squeezed through the teeth like a deep "ooh" or "ow." It voices the difficulty and the pain the patient suffers in standing. A moment later, as he pushes himself further out of the chair, the patient utters "ooh::(er)"—expressing the pain in standing. Even the way in which the patient stands embodies his difficulty. As he raises himself out of the chair, he holds the torso steady, as if the back is inflexible and the ordinary, fluid bend entailed in rising would inflict further pain. The doctor continues to look at the records.

On standing, and just as he is about to leave, the patient turns back to the doctor and utters "(Did you see) just when I got up." The utterance points to suffering the patient has just incurred. The doctor turns toward the patient and, as he does, the patient reenacts the difficulty he has/had standing. The reenactment is coupled with a cry of pain "Oooh:" (Figure 10)—a cry that nicely demarcates the significance of the enactment. The doctor witnesses what he missed a moment before.

In finding the "actual" suffering pass without notice, therefore, the patient, now having the visual orientation of the doctor, reenacts the experience he incurred a few moments earlier. It simply secures an acknowledgment, a downward intoned "yeh"; the doctor proffers no further inquiry nor appreciation of the suffering. The patient immediately transforms the suffering into a "laughable," ridding it of diagnostic and investigative import (Sacks, 1975, 1992; Sudnow, 1967). The doctor aligns toward the patient's treatment of his own suffering; he responds with a chuckle and returns to the records.

The patient's alignment toward the doctor's version of the complaint, its significance, and the overall reason for the visit is developed in an interesting fashion a few moments later. Much of the consultation has been taken up with a discussion as to whether the patient should drive again. After lengthy discussion, and some resistance, the patient agrees with the doctor's recommendation that he should not use the vehicle. As he leaves the consulting room, the patient turns round and says "an when I try and get in the car::::." He then pretends bodily to maneuver into a car and produces a lengthy cry of pain "ooooooh::." The doctor once

Thank you very much

Figure 8.

°hhtha(h)nk y(hh)ou

Figure 9.

Oooh: there

Figure 10.

again delivers a minimal acknowledgment "Yers:" and the patient once again produces a token laugh. As he thanks the doctor, the doctor interjects with the moral of the tale, a "bit of walking will do the patient some good." The patient not only aligns with the doctor's version of the principal reason for the consultation, treatment for the stroke and the ability to undertake certain activities, but puts his arthritic pain, its momentary occurrence and reenactment to the service of supporting the doctor's recommendation that he should no longer drive a car.

In different ways, therefore, we find patients toward the end of the consultation attempting to topicalize symptoms they happen to experience then and there. The doctors provide, at least initially, no vocal response to the display, nor do they turn to and look at the patient. In neither case are they seen to witness the actual symptom and suffering. They preserve their orientation toward a particular object or artifact, an object that preserves a course of uncompleted action—passing the prescription to the patient or reading and writing records following the consultation's completion. The artifacts become a resource within the negotiation. They provide the doctor with an account for not looking up and project a relevant course of action that differs from the potential trajectory invoked by the symptom and suffering. In both cases, the patient then explicitly nominates the symptom or suffering as a topic or point of discussion, but then, seeing how the doctor responds, quickly rids the symptom of its sequential import by making it lighthearted and not necessarily requiring further discussion. Using laughter, the patient allows the doctor to not pursue the projected matter and its potential sequential import. In and through their negotiation, patient and doctor preserve, or better reestablish, alignment toward the matters-in-course, the original trajectory of conduct, the symptom and suffering failing to engender further inquiry or diagnostic significance.

Description and Demonstration

We began by considering the ways in which patients animate parts of the body to provide the doctor with an appreciation and significance of their complaint and,

in particular, their suffering of the difficulties. In the previous section we also began to consider how patients may attempt to reveal their actual momentary experience of their symptoms to the doctor. In both cases, these demonstrations and displays of suffering are designed not only to give expression to the complaint, but to encourage the doctor to see, and respond to, the patient's symptoms and their passing revelation. I would like to draw these various elements together and consider, in a little more detail, how patients attempt to fashion the participation of the doctor and secure the diagnostic relevance of these symptomatic illustrations.

Consider the following fragment drawn from the beginning of a consultation; the patient is returning to discuss the progress of his illness and its treatment.

Fragment 5.

→ Dr: How are you do:in:?
(0.8)
P: Well I still get very tir:ed: (0.7) walking (.) sweat:.
(0.8)
Dr: Yeh
(.)
P: hhhhhh
(0.8)
P: I er:m::: (0.6) wrote down that er:: (0.4) sick place about that permanent retirement you know Doctor.

As the patient responds to the doctor's query, he begins to reveal his symptoms. With the word "tir:ed:" (Figure 11), he shakes his head from side to side and progressively looks down as if overcome by exhaustion. He then begins to look up and adds the word "walking(.)" and mentions an additional symptom "sweat:." (Figure 12). With the word "sweat," he mops his brow and momentarily holds his hand up and inspects the imaginary sweat he has removed from his brow. Parts of the body are not simply animated in the description, but the symptoms demonstrated, revealed, then and there for doctor. The doctor is able to witness the patient's suffering when he attempts to walk.

The doctor provides no immediate reply. He neither acknowledges the difficulties nor initiates a series of further inquiries into the changing character of the illness. He appears to be looking at the patient but remains silent and unresponsive. As the patient mops his brow, the doctor turns to the medical records and a moment later produces "yeh." The shift in orientation, the engagement with the record, and the downward intoned "yeh" provide little acknowledgment and certainly display no appreciation of the suffering apparently incurred by the patient.

The patient does not abandon his attempt to explicate his symptoms. Once again he attempts to reveal, rather than simply describe, his difficulties. He turns to one side and exhales loudly as if exhausted and short of breadth. The doctor continues to read. It is the patient who takes the floor to speak next. He abandons any further attempt to describe or demonstrate his experience of his illness.

The patient makes successive attempts to have the doctor see and respond to

Well I still get very tir:ed:

Figure 11.

walking (.) sweat

Figure 12.

(0.8)

Figure 13.

the difficulties he is suffering. In producing each of the demonstrations, the patient is sensitive to the alignment and response of the doctor, and builds the dramatic force of the revelation to secure acknowledgment from the doctor. The demonstrations, although perhaps seen, engender little response and do not encourage the doctor to pursue further investigations into the character and significance of the symptoms. Perhaps unsurprisingly, but certainly unusual for a medical consultation, it is the patient who realigns the trajectory of the business at hand, initiating discussion concerning his dealings with the local, and abandoning any further attempt to discuss or reveal his symptoms. The shift of topic serves to initiate what is sometimes characterized as the management phase of the consultation, and the shift proves successful in that the doctor is quick to respond to and discuss how the matters in question might be handled. The patient's demonstration therefore appears to achieve neither interactional nor diagnostic significance; it amply becomes subsumed under the general management of a previously diagnosed complaint.

It may be helpful to consider in a little more detail why patients in certain circumstances produce these dramatic demonstrations of their symptoms and try to provide the doctor with an appreciation of the experience of suffering. For example, it can be difficult for patients to provide doctors with an idea of the location and specific character of pain that they are suffering, and it is not unusual to find extensive diagnostic sequences through which the doctor attempts to identify just where and what the difficulty is. In the following consultation, the doctor is attempting to identify the character of the patient's pain and under what circumstances it arises.

Fragment 6.

Dr: What sort of pain is it?
Dr: is it err: (0.7) it is a shar:p ↑ ache or a: or a dull::?
P: A dull ache, you know
Dr: mmmh
→ P: It's er:::: (1.2) not too bad er:: if you're lying down but when you get up on it (0.2) it.err (.) y'know {patient attempts to rise}
Dr: Ri::ght. (0.7) What about when you're walking about . . .

The doctor's uncertainty, almost quizzicalness, about the character of the pain has the patient attempting to describe the circumstances under which it is more or less severe. The patient constructs a two-part utterance through which he contrasts the occurrence and severity of the pain. The second part of the utterance however appears incomplete, with the patient failing to give an appreciation of the occasioned severity of the difficulty. As he begins the utterance, the patient reaches for his leg and strokes the area of difficulty. As he begins the second part of the turn, he momentarily grasps his leg, lurches forward, and then sits back as if in sudden, severe pain.

The demonstration neatly couples the action of getting up with a revelation of the suffering that is so severe that it throws you back in the chair. It allows the patient to provide the doctor both with a description of when the difficulty occurs, but perhaps more importantly, with an appreciation of the nature and severity of the suffering. It nicely contrasts with the "dull ache" proposed by the doctor in the previous turn. It becomes literally apparent that, although the leg does indeed provide a dull ache much of the time, during particular activities the pain is acute and severe, undermining the patient's ability to undertake simple tasks like getting up. The demonstration serves to provide the doctor with just the sense of the problem for which he has been searching. It momentarily renders visible the "actual" complaint; it allows him to witness its character and severity and to see for himself when and how it arises. The pain, if you like, is revealed on cue. It is occasioned by, and demonstrated then and there within the interaction, and provides the resources for further inquiries, a diagnosis, and management. It also allows the patient to show, rather than claim, that it is not simply a dull ache, but a pain that can interfere with one's ability to undertake relatively mundane activities.

The Diagnostic Relevance of Bodily Revelations

In passing it is perhaps worthwhile to reflect upon the interactional and diagnostic relevance of these bodily animations of symptoms and suffering and in particular the extent to which they bear upon medical assessment and the management of illness. In a number of the cases we have discussed so far, in particular where the revelations are specifically disregarded by the doctor, there is little evidence to suggest that they bear upon diagnosis or treatment. Indeed, as we have suggested, some of these revelations arise in circumstances where there is potential incongruence between the patient's and doctor's assessment of the complaint—the bodily animation serving to (re)assert the significance or seriousness of a particular symptom toward the end of the consultation. In some cases, however, we do find doctors explicitly addressing the patient's gestural characterization of their symptoms and suffering and, for example, attempting to present their diagnosis or assessment with regard to the patient's distinctive experience of their problem (also see Heath, 1992; Peräkylä, 1998).

Consider one such instance. It will be recalled that in Fragment 1 we found a particularly dramatic characterization of the patient's symptoms and suffering: headaches, puffy/swollen eyes, and dizziness. We join the action a few moments

(The) the sensation of pressure:

Figure 14.

yeah - it's like a ban::d

Figure 15.

after the earlier fragment. The doctor has examined the patient's eyes and then presents his "diagnosis" or assessment of the difficulty.

Fragment 7.

Dr: I think the h<u>ead</u>aches: are what we call tension headaches<due to the <u>sh:o</u>ck
P: =mm ⌜ hm
Dr: ⌞ (the) the sensation of pressure (.) tha tha tha<u>t's</u>: (.) what you're describing (. . .) isn't it the tightness an: (0.2) °hh the top of you head
Dr: *hh ⌜h that's ⌜ tha
P: ⌞Yeah ⌞ it's like a ban::d ⌜ (how'd)
Dr: ⌞Yeh
P: you(d) describe it being tightened really
Dr: that was `the shock which did that
P: um
Dr: I'm sure about that. But the . . .

The doctor delivers a recharacterization of one of the patient's difficulties—namely "tension headaches"—and attributes the problem to a shock that the patient has experienced. He then goes on to explain how the patient's symptoms fit with his characterization. The explanation is accompanied by a series of gestures (Figure 14) through which the doctor reproduces the display provided earlier by the patient. He positions his hands at successive locations around his head and simulates pressure. His utterance, "tha<u>t's</u>(.) what you're describing," invites the patient to confirm the diagnosis.

The doctor's imitation of the patient's dramatic description of the problem arises in the light of the patient's response to the diagnosis and his sensitivity to its potential delicacy. The patient's initial response "mm hm" serves as a minimal acknowledgment, a weak agreement with the characterization, and the doctor moves quickly to relate the diagnosis to the patient's dramatic description of the

problem. The doctor's continued sensitivity to the legitimacy of his characterization is perhaps further displayed in his attempt to have the patient agree with the proposal. He receives no further acknowledgment, either vocally or visually, and once again reproduces his imitation of the patient's gesture, this time providing a more dramatic enactment of the pressure on the head.

The doctor's sensitivity toward the legitimacy of his own characterization is perhaps well founded. As he attempts to continue, perhaps to try and convince the patient, she interjects: She represents her problem, "it's like a ban::d" (Figure 15). With the description, she gesturally simulates a band tightening around her head. Once again the doctor asserts his version, "the shock which did that." His orientation to her continued lack of commitment is well captured in his further utterance, "I'm sure about that," and his attempt to move quickly onto the second part of the assessment (hay fever). Even then, in presenting the "diagnosis," he immediately stands and reexamines the patient's eyes as if visibly reconfirming his diagnosis of the complaint and showing the bodily, empirical basis to his version of the complaint.

One of the few occasions, therefore, where the doctor explicitly orients to the patient's gestural characterization of the difficulty arises where there is potential incongruence between the patient's and doctor's version of the complaint. In the case at hand, the patient appears resistant to the doctor's recharacterization (diagnosis) of the symptoms that she has experienced. The doctor's attempt to tailor the diagnosis more specifically with respect to the characteristics of the complaint presented by the patient emerges in the light of the coparticipant's conduct and in particular her minimal alignment with both the visual and vocal recharacterization of her illness. The patient's resistance, and the doctor's initial sensitivity to his own diagnosis, may derive from the ways in which it potentially undermines the seriousness of the problem—a tension headache, however severe, is a passing, self-manageable difficulty and does not necessarily warrant medical intervention. Indeed, the patient's relief in finding that she is not suffering from something more serious may be tempered by the fact that the diagnosis undermines her characterization of the problem and perhaps her reason for seeking medical help.

Discussion: The Revelation Suffering

In very different ways, therefore, we can begin to see how patients give expression to their suffering during the medical consultation. Patients do not abandon themselves to suffering, but momentarily reveal their subjective experience of their difficulties within the framework and practicalities of the consultation. The patients attempt to make symptoms come alive, to give them a presence then and there within consultation, and allow the doctor to see for himself the suffering they have incurred. The doctor is encouraged to witness the patients' symptoms and suffering. As we have seen, case by case, there are various circumstances in which patients may attempt to reveal their suffering to the doctor, though it certainly does not happen in all consultations.

It is generally recognized in medicine and professional practice that pain and

suffering are notoriously difficult for patients to describe. Almost any clinical textbook provides practitioners with instructions and procedures through which they can attempt to determine the location and character of pain and discomfort suffered by patients. In many of the cases at hand, we find patients enacting and demonstrating their suffering to enable the doctor to gain an appreciation of the actual difficulties. In some cases, investigation has already been directed to determining the location and quality of the pain, and revelation itself arises in circumstances where patient and doctor have been unable to assemble a determinate and common understanding of the difficulty in question. Even in cases where the location and quality of suffering have not become an issue in their own right, we can find patients attempting to provide the doctor with an appreciation of the particular intensity and character of their pain and suffering—qualities that may not be easily articulated within talk, and in some cases the sequential opportunities provided by the doctor. These demonstrations and enactments provide patients with distinctive ways of expressing pain and suffering and giving it a determinate sense and quality that it might not otherwise have.

In this respect, consider how this is so. In general practice, patients are provided with an opportunity to describe their difficulties "in their own words" (cf., Byrne & Long, 1976) at the beginning of the consultation; in "return appointments" they update the doctor on the progress of the complaint. In describing their symptoms, patients often propose, tentatively, a candidate diagnosis or assessment, for example, "wondered if I had tonsillitis," or "it might be a touch of bronchitis." Even the description of the troubles invoke, as we have seen, conventional categories of symptoms—sore throats, headaches, sweats, coughs, heart pain, tiredness, and the like. Indeed, it is relatively unusual, perhaps unsurprising, to even find peculiar combinations of symptoms, at least in general practice. Enactments and demonstrations provide patients with the possibility of presenting the unique and distinctive qualities of their illness and suffering. It is not, for example, any headache, but a dramatic, intense, localized pain that renders the head highly sensitive; not any sore throat, but one that clasps the throat and chokes; not any pain in the chest, but pain that momentarily overwhelms, and so forth. In other words, enactment and demonstrations display the unique and particular qualities of pain and suffering—they give a distinctive sense and significance to generic categories of complaint and symptom and they provide particular characteristics to conventional ways of describing (and diagnosing) illness.

Patients have to provide reasonable grounds for seeking medical help and, if relevant, gaining access to the sick role. Many of the difficulties with which we turn to the doctor are relatively trivial problems that are potentially self-manageable and do not require professional help. Enactments and demonstrations not only allow us to give unique qualities to generic categories of mundane troubles, but they help provide evidence of the difficulty and its severity in the particular case. In the same way that one's voice may be overcome with suffering when trying to excuse oneself from a dinner party because of a bad cold (though in many cases we upgrade it to flu), so patients, through their enactments and demonstrations, underscore the uniqueness and severity of their complaints and provide good grounds for turning to the doctor. It is hardly surprising that we fre-

quently find the more dramatic demonstrations arising in circumstances where there is a potential tension, or incongruity, between the patient's assessment of the complaint and the doctor's diagnosis. The patient is attempting to upgrade the severity of trouble and underscore grounds for seeking help and particular forms of treatment or management. In revealing their problems, patients provide the doctor with an opportunity to see the very suffering incurred by the patient and the seriousness of the problem.

One aspect of the delight of these demonstrations is the ways they are designed to fit the circumstances at hand and, in particular, the emerging coparticipation of the doctor. There is not the space to address their design in detail, but one brief point is raised. In the first place, a variety of bodily animations are organized with regard to the doctor's visual orientation and in some cases the patient's successful attempts to realign his gaze toward the relevant parts of the body. Some, like Fragments 1 and 2, are nicely and obviously played within the natural focal area of the doctor's orientation; shaped occasionally (as in Fragments 2 and 3) to realign the orientation of the doctor back toward the speaker and, inevitably, the gestural display of the difficulties. Others, if only by virtue of the location of the symptom, demand the patient to reshape the visual orientation of the other to enable the gesture to establish its viewer and sequential significance. As I have suggested elsewhere, and hinted during the article, many of these illustrations and demonstrations are not designed simply to provide an embodied portrayal of symptoms of suffering, but simultaneously shaped to establish particular forms of co-orientation and participation (also see Heath, 1986, 1989). Indeed, in particular cases, including, for example, Fragment 5, the exaggerated display of exhaustion and inspecting one's own sweat followed by the loud exhale, are designed to encourage the doctor to see and respond to the demonstration. Perhaps most dramatically, the patient's sensitivity to the recipient's alignment toward these revelations is powerfully demonstrated in Fragments such as 3 and 4, where the patient retrospectively marks what happened, and in Fragment 4 even recycles the demonstration. The second is inevitably an imitation of the first; the dramaturgical perspective in action and as a "reproduction" it rids the revelation of its potential significance.

In demonstrating—even dramatizing—their symptoms, patients give expression to their suffering and symptoms while systematically preserving the characteristic organization of the consultation. They give unique qualities to their complaint, they provide evidence of their difficulties, and they reveal their suffering within the turn-by-turn sequential organization of the interaction. The illustrations, enactments, and demonstrations are largely produced with and within talk. They are accomplished within the legitimate framework of a turn at talk and the opportunities afforded through the sequential organization of the interaction. As we have seen, a symptom's production may be suppressed until an opportunity arises within the talk, or a profound revelation of suffering may be built within and through an utterance so as to preserve the relevant sequential character of an action. This is not to suggest that patients do not attempt to build themselves opportunities within the talk to express and expose symptoms and suffering, but rather that their ability to reveal their complaint is dependent upon and accom-

plished through the characteristic sequential organization of the consultation. So, although on the one hand patients provide an appreciation of subjective, sentimental experience of their difficulties, they simultaneously preserve a relevant standpoint toward their own complaint and thereby allow the doctor to undertake his investigations and implement management. Patients exploit opportunities that arise within the talk not simply to describe but to display the experience of their symptoms and suffering.

Patients, through animation, illustration, and demonstration, are systematically able to provide a sense of their suffering, their subjective experience of their complaint and its symptoms. They transpose subjective, interpersonal experience and overlay that experience on their body's surface. Through gesture, bodily comportment, and talk, they render visible what would otherwise remain hidden and unavailable for inspection. Through their gestures and bodily comportment, patients also transpose difficulties and suffering that occur in other situations and at other times and reveal them then and there within the consultation. The doctor becomes witness to feeling and suffering that is inevitably subjective, personal, and sensuous, but he is able to see and experience for himself events that occur way beyond the walls of the consulting room, in the patient's life, which is unavailable to medical scrutiny. Finally, perhaps most fundamentally, patients transpose feeling and sensibility into conduct, into action. The doctor is provided with the behavioral manifestation of suffering, and feelings are visibly portrayed and given a sense and significance that they would not otherwise have. Through these transpositions, doctors are not simply spectators, but are momentarily subsumed into the very production and revelation of symptoms and suffering.

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