Negotiating last-minute concerns in closing Korean medical encounters: The use of gaze, body and talk

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ABSTRACT

Although patients may raise new concerns during any time of the medical visit, the closing phase of the consultation is a critical focus for the negotiation of the topicalization of additional concerns. Using conversation analysis as the primary method of analysis, this study provides an analysis of the structure of consultation "closings" in Korean primary-care encounters and the way in which the organization of closings in this context discourages patients’ presentation of additional concerns. Data are drawn from 60 videotaped primary-care encounters collected from Korea, between 2007 and 2008. The rare occasions in which last-minute concerns are raised are closely analyzed to reveal that the organization of gaze and body orientation play an important role in foreclosing the presentation of additional concerns. The results contribute to our understanding of closings in the primary-care interview by investigating a non-western setting that includes an investigation of an understudied subject — that of embodied resources — and shows how these closings serve the doctor’s purpose of bringing closure in the face of last-minute concerns broached by the patient. The cultural meaning of gaze in the Korean medical care context is also discussed. The findings have implications for research on nonverbal communication, cultural differences, and interactions in medical care.

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Introduction

When patients visit primary-care physicians, they frequently bring several concerns, which can include not only medical problems but also requests for non-diagnostic advice and information (Campion & Langdon, 2004; Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007; Marvel, Epstein, Flowers, & Beckman, 1999; White, Levinson, & Roter, 1994; White, Rosson, Christensen, Hart, & Levinson, 1997). However, the opening questions of physicians, such as “How can I help you today” normally elicit single “current” concerns (Heath, 1986; Heritage & Robinson, 2006). In Korea, which provides the context for the current study, the most frequently employed question to open primary-care visits is eti-ka aphase wass-eya?, meaning “Where does it hurt?” which is structurally (through its linguistic design) and pragmatically (through its sequential placement) designed to solicit the primary and single reason for the patients’ visit (Park, 2009). In these contexts, patients’ presentations of their first concerns are taken as cues to progress through the activities and stages of history-taking, physician examination, diagnosis and treatment (Beckman & Frankel, 1984; Greathatch, 2006; Heritage & Maynard, 2006; Manning & Ray, 2009; Robinson, 2003). Because patients’ primary concerns are solicited by physicians at the beginning of consultations and those concerns presented later in the encounter are more easily ignored (Beckman & Frankel, 1984), raising the additional concerns of patients as topics of discussion can be challenging.

Managing the full array of patient concerns is important because studies show that physicians’ knowledge of the full spectrum of patients’ concerns is vital to the accurate diagnosis and treatment of medical conditions and the delivery of comprehensive and high-quality health care (Bates, Bickley, & Hoekelman, 1995; Fisher, 1991; Lipkin, Frankel, Beckman, Charon, & Fein, 1995; Mishler, 1984). In a study of 48 American primary-care practices, Robinson (2001) found that the primary moment for physicians to topicalize additional concerns is during the transition into closing activity, particularly, through questions such as “anything else?” When physicians do not solicit additional concerns from patients during these moments, patients may actively seek opportunities to state their concerns (Campion & Langdon, 2004; White et al., 1994). These concerns lead to the classic “by-the-way” syndrome (Byrne & Long, 1976) or what Campion and Langdon (2004) described as “in-situ announcements” through which patients try to introduce
previously unmentioned difficulties and engender further discussion about their problems. Although patients may raise new topics or concerns during any time of the medical visit (Campion & Langdon, 2004), the closing phase of the consultation appears to be a critical locus for the negotiation of the topologicalization of additional concerns (Heath, 1986). This paper explores the mechanisms by which physicians manage achieving visit closure in 60 Korean primary consultations and provides an analysis of how patients’ efforts to bring up additional concerns during the closing sequence are discouraged in the context of a normative primary-care consultation oriented to a single, most “current” problem (Byrne & Long, 1976; Heritage & Robinson, 2006; Park, 2009).

The closing problem and soliciting patient’s additional concerns

Studies have noted that participants face a fundamental challenge toward the end of the medical appointment in deciding how to coordinate their exit from the session (Robinson, 2001; West, 2006). This challenge, which Schegloff and Sacks (1973) refer to as “the closing problem” in ordinary conversation, is a general problem that participants have to solve whenever they plan to exit an encounter. Accordingly, the medical encounter cannot be terminated until participants display their mutual attendance to it as such. In the American primary-care context, the closing phases begin with the “arrangement-related” (West, 2006) or “final concern” business pre-closing sequence (Robinson, 2001), which discusses the action recommended by the physician after the current encounter is terminated (e.g., “I’ll see you again in a couple of months”) or involves the physician’s solicitation of “last” or “final” concerns (e.g., “Any other problems?”). West (2006) found that re-invocations of arrangements that had already been made (e.g., “Let me see you back here on Thursday afternoon”) occurred in 32 out of the 37 primary-care visits in which doctors initiated pre-closings. These pre-closing sequences in which arrangements are made deciding when the doctor will next see the patient generally lead to the actual closing activity, which is characterized by terminal exchanges (e.g., “bye”) (Robinson, 2001; West, 2006; White et al., 1994).

White et al. (1994, 1997) examined audiotapes of American encounters to show how closings in medical encounters begin with a shift from a present to a future orientation (with sentences such as ‘okay, well let’s do some blood tests’, ‘see you in three to four months’). However, their study relied on audiotape data and coders’ assessment of the talk; therefore, they did not have access to physicians’ and patients’ closing-relevant, embodied actions as evidence for what constituted transition-relevant places in the talk. Drawing on videotaped data from England, Heath (1986) analyzed the activity of closings as requiring tense negotiations between patients and physicians, indicating further that the last minutes of a visit are important for patients. While these studies have extended physician–patient interaction research by examining the communication practices employed in the closing phase of the encounter, they were primarily concerned with the organization of talk in the consultation and paid little attention to the ways in which physicians employ visual as well as spoken conduct. There also remains the task of establishing a framework for contextualizing such findings in a different cultural setting.

At least two of the contexts that characterize primary-care visits in Korea differ from those occurring in the United States. First, medical care in Korea is characterized by compulsory medical insurance with universal coverage, unlike current medical care in the US. Therefore, people in Korea freely choose among family physicians and the outpatient departments of hospitals rather than having a single family doctor or attending physician. Second, medical services are reimbursed on a fee-for-service basis (patients pay approximately 3 dollars out-of-pocket for each visit with a 74% reimbursement rate) which explains the large number of patients (over seventy patients) that doctors see on a single day to remain profitable (Cho, Hong, & Park, 2004). This medical system may motivate the doctor to see as many patients as possible, which in turn may influence the interactional organization of closings between doctors and patients in primary-care consultations.

The aims for this study are, first, to describe the turn-by-turn organization of closings in the Korean primary-care context by investigating how physicians and patients collaboratively achieve visit closure, and second, to offer an analysis of the embodied practices that physicians use to negotiate a transition to the closing activity by exploring the rare exceptions (three out of 60 cases) when last-minute concerns arise. In particular, the position in which additional concerns are brought up will be analyzed to show how the patient’s efforts at presenting new concerns are discouraged by the doctor. Because the data are collected in a non-Western context, the results add to the findings from previous studies on the organization of closings largely conducted in American and British medical care settings (Campion & Langdon, 2004; Heath, 1986; Heritage et al., 2007; Rhodes et al., 2008; Robinson, 2003; West, 2006; White et al., 1994, 1997). An example of a non-American/British study is that of Nishizaka (2010) who studied how pregnant women raise problems in Japanese regular prenatal checkups; however, the author did not address the closing problem, either, instead on the mutual dependence between the position and construction of problem presentations. The current study thus contributes to our understanding of how unmet concerns are dealt with in a non-Western health care setting, where the interactional organization of closings is managed in a somewhat different way. Finally, this study adds to our understanding of the interdependence of talk and bodily conduct during the medical closing activity and to the cross-border or cross-system extension of existing knowledge.

Data and method

The current data are drawn from a body of 60 videotaped primary-care encounters collected from seven private clinics and hospitals in Seoul, Korea, between 2007 and 2008. The participants (physicians and their patients) were selected on the basis of their willingness to participate. All data collection was approved by a university human subject protection committee (#G07-06-021-01), and consent forms (including an agreement to be recorded and to allow the use of photographs in published manuscripts) were obtained from participants. The nursing staff at each health care facility identified potential participants and initially asked whether they would be interested in participating. If the patients gave permission, the researcher approached them in the waiting area, explained the goals of the study and obtained informed consent. Once the researcher had obtained consent from the patient, she would inform the nurse, who would then turn on the video camera before the patient entered the doctor’s office. The filming continued until the visit was complete, at which point the nurse turned off the camera.

The physicians included four males and three females. Five of these physicians were currently professors at various universities in Seoul; only one of the seven physicians was a resident doctor in training. The mean age of the patients was 48 years. Sixty-seven percent of the encounters were with male physicians and 52% of the patients were women. Out of the 60 collected visits, 24 were for acute problems in which the patients visited the clinic with new concerns such as influenza, headache or cough. Seventeen visits were routine checkups to monitor the patient’s glucose level or blood pressure, and the remaining 19 were follow-up visits for an earlier reported problem (e.g., a cold or back pain).

The videotaped data were transcribed using conversation analysis methodology, as applied to the study of institutional
interactions (for a review of conversation analytic studies on medical interactions, see Heritage & Maynard, 2006). The data were first transcribed in Korean and relevant sections were later translated into English using a three-line transcription system used for the Korean language. Korean was romanized using the Yale system, which represents the actual sounds rather than the standard orthography of Korean. The three lines used in the transcript represent the sound (line 1), morpheme-by-morpheme gloss (line 2) and the English translation (line 3), respectively. The transcripts also juxtapose images — framegrabs from digitized video stills — and excerpts from the conversation, with arrows often connecting concurrent talk and actions. All names were changed to pseudonyms in the data extracts used for this article.

Two of the seven physicians who agreed to be interviewed were later visited by the researcher, who showed them a copy of the transcript and the researcher’s analysis. A copy of the transcript and video material was provided upon request (only one doctor requested the video recordings). In the following sections, four closings are examined. Closing 1 is representative of the closing activity found in the data set. Closings 2–4 represent the three cases (out of the 60 consultations) in which patients presented last-minute concerns.

Analysis

The organization of closings in Korean primary-care consultations

Prior to analyzing cases in which patients present last-minute concerns, a demonstration of and preliminary observation on the organization of closings in Korean primary-care consultations will be provided. The analysis will demonstrate how both the tendency for opening questions to solicit only one concern and the organization of closings in Korean medical care as oriented to visit closure contribute to the small number of patients (3 out of 60) who raise additional concerns in this context.

Openings in Korean primary-care consultations are commonly concerned with three main generic issues: greetings and getting seated (1→), establishing the identity of the patient (2→), and the solicitation of a main concern by the physician through a question (3→) (cf. Robinson, 1998). Opening 1 illustrates the way in which these three issues are organized during the opening phase of a visit to a Korean family care hospital.

Opening 1. C1: articular rheumatism

01 DOC: 1→ yey tule-o-sey-yo.
yes enter-come—SH:IE-POL
1→ Yes come in. (bows his head slightly)

02 (5.0) ((patient enters and pulls up a chair.))

03 DOC: 2→ ki::m kim [kim.
(last name X3)
Ki::m Kim [Kim. ((while gazing at the computer screen))

04 PAT: 2→ [kim kim taywuni-yo.—
(last name X2) (name)=POL
[Kim Kim Taywun.—

05 DOC: 3→ =ney eti-ka apha-se o-sye-ss-eyo.
yes where-NOM hurt-so come-SH:IE-PST-POL
=Yes where did it hurt so that you came?

06 PAT: 3→ i ^sonkalak-iyo::,
this finger-POL
This ^finger::, (shows her index finger to the doctor)

07 DOC: yey.
Yes:POL
Yes.

The visit opens with the doctor calling in and greeting the next patient, tuleoseyyo, “come in” (line 1), and the patient entering the consultation room where the doctor is seated (line 2). Unlike US consultation rooms, where physicians see patients by moving around to different examination rooms, Korean physicians remain in their own offices while patients enter and leave the room. At line 3, the doctor enters into a kind of name search with a sound stretch and a repetition of the patient’s last name (“Ki::m Kim [Kim]”). At line 4, the patient joins the search by first repeating her last name in overlap (“[Kim]”) followed by her full name (“Kim Taywun”). This turn is immediately followed by the doctor’s brief confirmation of the patient’s name ney “yes”. Here, the identity of the patient is collaboratively established. Immediately following this confirmation, the doctor asks a problem solicitation question in the form of etika aphase wasseyo, “where did it hurt so that you came?” (line 5), which literally asks for the location of the patient’s pain. At line 6, the patient expresses the location of the problem (“this finger::”), which is then acknowledged by the doctor (yey, “yes”). Accordingly, the problem solicitation question is oriented to a single reason for the visit, and, in this case, a response that presents the specific location of a problem. Closings also contribute to the presentation of one problem by allowing no opportunity for patients to reveal additional concerns, as will be shown below.

In the Korean data collected for this study, closings regularly consisted of two phases: 1) future arrangement sequences that...
included either instructions regarding treatment or the announcement of events that will occur after the encounter ends and 2) terminal exchanges (e.g., “bye”−“bye”) that included all communication behavior until the successful termination of the encounter (i.e., patient walking out of the office). Closing 1 represents a typical closing sequence found in the majority of the collected Korean primary-care consultations. Each phase is indicated by arrows (1→, 2→). Unlike the majority of visits examined in West (2006), which ended with a collaborative terminal exchange (e.g., “thank you”−“thank you”, “bye”−“bye”), the Korean consultations included many instances that ended with a terminal utterance from only one of the participants, as shown below.

Closing 1. CHOI closing

143 DOC: coy-ka yak-un yo ppwum-nun yak I-NOM medication-TOP this spray-ATTR medication phyengso ssu-si-nun ke. Usually use-SH-ATTR thing

1→ As for medication, (I will prescribe) this spray medication, the one (you) usually use.

144 e? [yo-ke-man cey-ka chepang-ul twulli-kkey-yo. Ok thing-thing-only I-NOM prescribe-ACC give-will-FOL

1→ Okay? [I will only be prescribing this.

145 PAT: 1→ ((nods her head while shifting her body))

146 DOC: ye-y kule-sey-yo:: yo. Yes:FOL so-SH-FOL yes

1 → [Yes do so::: Yes.

147 ((the patient shifts her body toward the door))

148 PAT: swukoha-sey-yo. work-hard-SH-FOL

2 → Goodbye.

149 ((The patient leaves the room and closes the door behind her while the doctor gazes toward the screen))

What follows is a detailed examination of Closing 1, which includes the doctor’s and patient’s gaze and body orientation practices.

Coordinating gaze and body behavior to establish closings

In Closing 1, the patient’s primary reason for visiting the physician is to treat a vomiting problem (an acute symptom); however, the patient ends up being treated for her rhinitis, which she has been suffering from (a routine problem), at which point we pick up the conversation. The physician’s prescription (“spray medication”), together with the use of the word chepang, “prescribe”, communicates that closing is relevant (line 144, “I will only be prescribing this”). These types of prescription-related comments (e.g., yak samil mekeyo “Take the medicine for three days”) provide a typical environment for pre-closing in these Korean contexts. These pre-closing sequences may be compared to those found in American contexts, which largely involve making arrangements regarding when the doctor will see the patient next (Robinson, 2001; West, 2006) or a re-invoking of treatment (West, 2006).
As the patient nods her head in acceptance (which constitutes the second pair part of the pre-closing sequence, line 145), the doctor begins to turn his gaze away from the patient and says *yey kule-seseyo:* *yey,* “Yes do so::: yes.” Although not met with a verbal exchange from the patient, this utterance acts as a possible preclosing because both speakers pass the floor to one another without contributing to the topical development (West, 2006, p. 384) while disengaging their bodies from one another. This movement visibly marks the transition into the closing activity. The patient treats the doctor’s shift in gaze and utterance of *yey,* “yes,” as an indication that the closing is imminent by turning the chair and simultaneously shifting her body toward the door (line 147). Heath (1986) also showed how a patient’s acceptance of a preclosing offering co-occurs with his or her starting to take leave of the doctor. During the preclosing moment, the doctor projects impending disengagement through his gaze (Goodwin, 1980), and the patient collaborates in the closure of a designedly last topic (prescription giving) by shifting her body away from the doctor.

After the preclosing sequence (1 →), in which the participants collaborate toward building a closing environment, the patient produces a terminal utterance *sukohaseyyo,* “goodbye” (2 →). This utterance is met with silence rather than a rejoinder from the doctor. The term *sukohaseyyo* can literally translate into English as “work hard” and is different from the more general term *amnyenghikeseyo,* “goodbye,” commonly used to close ordinary conversations in Korean. The former term is normally reserved for use in institutional contexts or service encounters in which there is an asymmetry in power relationships between the participants. The asymmetrical character of this utterance in addition to the lack of mutual eye contact and the fact that the doctor and patient are no longer visually monitoring one another while leaving the consultation (Heath, 1986) may help to explain the absence of a reciprocal farewell. Fig. 1 shows the videotape frames that occurred during lines 146–148 of Closing 1.

As the physician initiates “Yes” (line 146) his gaze shifts toward the computer, which communicates that he is shifting his attention from the patient to the official record and transitioning into a new activity, the closing (Goodwin, 1981; Schegloff, 1998). The patient orients to the doctor’s shift in gaze from herself to the computer record as communicating his disengagement with her embodied self and his engagement with the next activity. As the doctor’s gaze moves away, she responds to the doctor’s confirmation and pursuit of an agreement from the patient to take the medication (“Yes do so::: Yes”) with “Goodbye”, thereby closing the visit and leaving the room.

As shown above, by the end of phase 1, physicians and patients start displaying signs of a disengagement framework (Goodwin, 1981) from the joint transactional space (Kendon, 1990) that they had maintained to this point during the visit. At lines 146 and 147, the patient shifts her gaze in coordination with a shift in the physician’s gaze, which is being directed toward the computer screen (Fig. 1). Therefore, it appears that, among other things, the shift in the physician’s gaze occasioned the patient’s disengagement from the consultation. The shift in gaze provides the doctor with a powerful interactional resource with which to signal disengagement, similar to the gaze shift used by the nurse between the computer screen and the patient in the study of Rhodes et al. (2008) on primary-care diabetes clinics. Psathas (1990) reported that a doctor directs the patient’s gaze by moving his own gaze to a notepad and thereby establishes the relevance of the object for the encounter. Similarly, Robinson (1998b) described how a doctor’s gaze shifts to and from patients in conjunction with talk and how the activity of writing on an intake pad, is integral to moving the interaction through the phases of the medical consultation. In Closing 1, after the doctor’s verbal pursuit of the patient’s future adherence (“Yes do so::: Yes.”), and his head movement (gaze shift) toward the computer, the patient collaborates in the closing activity by enacting closure (standing up and saying “goodbye”). This swift transition into phase 2 (terminal exchanges) results in an absence of parting comments that could enable the participants to relate on a personal level.

Based on the current data, the interactional structure of closings in Korean acute visits to primary-care offices can be depicted as follows (Fig. 2). In phase 2, reciprocal exchanges are less common than a single farewell as shown in Closing 1 above.

Similar to closing-relevant environments described by previous studies (Robinson, 2001; West, 2006), here, turns 1 and 2 above represent the activity that doctors physically engage in, followed by the patient’s acceptance of the proposal. However, unlike the doctors described in West (2006), who initiated closing activities by making arrangements to do something at a later time or by reiterating arrangements that had already been made, the majority of physicians in the Korean primary-care context communicated that closing is imminent by giving a prescription, which was frequently accompanied by proposals for future adherence. According to Berg (1996), physician actions such as underlining written notes, followed by the closing of the patient record, send a clear message to the patient that the consultation is over. Because the act of writing or handling paper records is not always relevant due to the current computerization of patient records, doctors more often appear to employ nonverbal resources such as embodiment and gazing in the direction of the computerized medical record to communicate that closing is the relevant next action. Turns 3 and 4 are occupied with either a terminal exchange, “bye,” or a ‘thank you’ type of closing (e.g., “Thank you”, “Okay”), which constitute the actual closing (→). As shown in Closing 1, the sequence frequently includes only one turn, and this turn could also be expressed through nonverbal cues (e.g., head nods).

This turn-by-turn organization raises another important question. In most of the closings found in the current Korean primary-care data, questions that ask about additional concerns at visit ends, such as “Anything else?” are almost never used. In the entire data set, only one instance occurred in which the physician asked the patient for additional problems through the question, *tto talun myuncsey issuseyo?* “Do you have another problem?” West (2006) also reported in her study that only in four out of the 48 cases in her data did doctors initiate closing sections by explicitly asking patients if there was any other concern that they wished to talk about. In Heritage et al. (2007), less than 5% of the patients from their non-intervention cases were asked about additional concerns, and all of these inquiries emerged after the presenting concern had been fully dealt with and the visit was ending.

In this near absence of physician questions to elicit additional concerns, in three out of the 60 cases collected in this study, patients actively presented additional concerns after phase 1 of the closing organization. In the following paragraphs, the three closings in which patients raise additional concerns are analyzed. In this process, I pay close attention to the embodied behavior of the physicians during turns that are launched as precursors to closing...
the medical consultations, and provide a sequential and lexical characterization of additional concerns raised to show how the patients’ efforts to raise last-minute concerns are discouraged.

The management of last-minute concerns

Patients raised additional concerns in three out of the sixty consultations. This proportion is similar to that found in the study of West (2006), in which two out of 48 patients raised new or emotionally charged concerns during the closing minutes of their consultations. The question of interest was how physicians and patients in Korea coordinate the effective management of last-minute concerns during the closing minutes of consultations. This is an important question to consider for doctors who face the task of maintaining a good relationship with the patient by attending to their concerns while concurrently achieving a high patient turnover rate by bringing in the next patient, who might have been waiting outside for more than an hour. In Korean university hospital settings, which were examined in this study, lengthy waiting times are common (Yoon & Kim, 2003) because of the large number of patients. Post-interviews with doctors revealed that they do not like to deal with last-minute concerns, which they believe would most likely lead to lengthier visits (see Heritage et al., 2007 for a study that showed otherwise).

Closings 2–4 demonstrate how physicians employ resources such as gaze direction and body movement to curtail the development of last-minute concerns when patients raise them during the pre-closing sequence and how patients coordinate closings in accordance with this behavior. Let us begin with an analysis of Closing 2. The patient, who is in his sixties, visited the hospital due to a lung problem. Before any treatment recommendation can be made by the doctor, the problem must be diagnosed using X-ray results, and the doctor provides instructions concerning what the patient should do next (lines 137–139: the first pair part of the arrangement sequence). Immediately after the doctor’s initiation of the pre-closing and in the subsequent turn space, a not-yet “mentioned mentionable” (Schegloff & Sacks, 1973, p. 312) is invoked by the patient at line 140 through the connective term kulikwuyo, “and”.

Fig. 3. Line 139 of Closing 2.

Fig. 4. Doctor’s gaze and body orientation during lines 143–149.
Closing 2. SS5 Last minute concerns

137 DOC: kualayse iltan yoke-n yo alaychung naylyeka-sye-se, so first this-TOP this lower.floor descent-SH-CONN
So first go down to the lower floor and,

138 PAT: ney.
Yes:POL
Yes.

139 DOC: sacin com ccik-ko cikum palo o-sipsi-yo.=
picture DM take-CONN now immediately up come-SH-POL
Take a picture and come straight up now.=

140 PAT: =kulikwu-yo.
And-POL

141 DOC: yey.
Yes:POL
Yes. (Doctor gazes at the computer screen)

142 PAT: yeki palo mith-ey-yo.
here right below-at-POL

143 DOC: >ney ney.<
yes:POL yes:POL
>Yes yes.< (Doctor turns his gaze toward patient)

144 PAT: yeki-ka: kulehkey ce:: wey ku swul moku-myen,
here-NOM very um DM that alcohol eat-if
ilen uica-ey ancu-myen telha-ntey,
these chair-at sit-if less-CIRCUM

Here it’s very um:: if (I) drink alcohol, If I sit down on these type of chairs it’s less (painful) but,

145 DOC: kalbi-ppye mith-ey-yo?
rib-bone below-at-POL
(are you talking about the area) below your rib bone?

146 PAT: [ney.
Yes:POL
[Yes.

147 DOC: [kalbi-ppye ]wui-ka ani-ko.
Rib-bone above-NOM not-CONN
[And it’s not above your rib bone[].

148 PAT: [ney ney.
yes:POL yes:POL
[No no.

149 DOC: ko mith-ey-nun, koki-ka kan-i
That below-at-TOP there-NOM liver-NOM
iss-nun cali-ntey-yo?
extist-ATTR place-CIRCUM-POL
But below that, that’s where the liver is?

150 PAT: koki-ka kulehkey com mwela kule-likha hwukkunha-kwu-jo.
there-NOM like.this a.bit what say-INTERR ache-CONN-POL
That place, how should I put it, it aches and.

151 DOC: e:::
Mm
Mm:::
Closing 2 begins with the doctor concluding the consultation by shifting the medical interview from a present to a future orientation (“go down to the lower floor and take a picture (X-ray)”, lines 137–139). As shown in the previous section (Fig. 2), the first pair part of the arrangement-making sequence is usually followed by terminal exchanges after the patient’s confirmation. The doctor’s body orientation and gaze direction during this sequence also promotes this reading. While giving directions, the doctor turns his whole body toward the computer screen (the black rectangle located at the right in Fig. 3), with his hand placed on the mouse, indicating that his dominant engagement now lies here rather than with the patient. Fig. 3 displays the doctor’s gaze and body orientation during these lines (139–140). The patient is seated to the doctor’s left in the picture. Unfortunately, the positioning of the camera made it difficult to capture the patient’s facial features and body orientation during this turn.

The physician’s instructions to the patient to take a picture and come up “now”, in addition to his body orientation toward the computer, strongly project a shift into the activity of closing that is contingent upon the patient’s confirmation and accompanying body movement (e.g. standing up). The patient also understands that the physician is transitioning into closing by immediately positioning an additional problem in this location. Precisely upon completion of the physician’s statement to “take a picture and come straight up now”, and before confirming the relevance of the next activity, the patient initiates a turn by latching onto the doctor’s “now” and projects an additional concern: “kulikwuyo, “–and”(line 140). This turn is structurally incomplete on its own and projects that more talk will follow. The doctor’s brief confirmation yey, “yes” (line 141) grants the patient permission to proceed with his attempt to topicalize an additional concern, which the patient does in the following lines. When utterances such as yeah, uh huh, mm hnh are all that the speaker produces in the turn, he or she often displays “an understanding that an extended unit of talk is underway by another, and that it is not yet, or may not yet be (even ought not yet be), complete” (Sacks, 1992, p. 140; Schegloff, 1982, p. 81). However, here, the doctor’s “yes,” which serves as a cue to proceed, is not accompanied by his gaze. In the next turns, the patient employs the deictic term “here right below” (line 142) and begins to describe the circumstances in which the pain does not occur (“If I drink alcohol, if I sit down on these type of chairs it’s less painful but”, line 144). Deictic terms such as “here” are frequently employed by speakers to direct the listener’s gaze (Goodwin, 1981); here, it appears to encourage the doctor to gaze back toward the patient. However, his body position does not allow him to fully direct his gaze at the patient’s body and his gaze remains at the mid-point of the desk (Fig. 4). While looking at this direction at the same time moving his left hand toward his rib area, the doctor asks “below your rib bone?” before the patient can finish describing the pain’s occurrence, possibly to determine the exact location of the patient’s pain. Twelve lines later into the interaction, the doctor states that if various places hurt like that it is nothing serious thus minimizing his professional responsibility toward the presented problem (Heritage & Robinson, 2006). Fig. 4 displays the change in the direction of the physician’s gaze and his engagement in body torque as the patient continues to present the location and occurrence of his pain until the doctor’s final conclusion on the irrelevance of the newly presented symptom to the currently addressed problem (line 149).

As shown in Fig. 4, the patient delays a detailed presentation of his additional problem until the doctor turns his head to look in his direction (line 143), which shows that an extended unit of talk that is being developed by the speaker cannot be sufficiently or appropriately addressed by the recipient (doctor)’s employment of talk (“yes”) alone. The doctor does not fully gaze toward the patient (his head is only turned halfway) and his body does not move away from the computer, which results in the doctor engaging in body torque (Schegloff, 1998). This divergent orientation of the body sectors (the upper and lower parts of his body are facing the computer screen while his head is turned to look at the patient) projects postural instability and indicates that the doctor’s engagement with the patient will be brief. In this interaction, it is interesting how the doctor constantly employs himself in body torque (lines 143, 145 among others) and avoids fully turning his whole body toward the patient even though this action could be easily performed by a mere turn of his chair, which is on casters. For example, while producing line 145 (“Below your rib bone?”), the doctor has to twist his upper body to turn his head toward the patient. His right arm remains on the table in front of him firmly holding the mouse. This is a strong indication in stance that the current interactional engagement toward the patient’s additional concern will be transient (Schegloff, 1998) and the doctor’s body is already exhibiting a pre-departure of the current attention. Immediately following this turn, the physician releases the torque by returning to the computer and sustains the medical record keeping activity and visit closure as the underlying interactional commitment (line 149).

When the doctor is assured that the patient’s pain occurs below the rib, he face the computer screen to direct his body toward the desk (the last picture of Fig. 4), thereby completely disorientation both his gaze and his body from the problem (and the patient). This is a visible indication of himself as a non-recipient occupied in a separate activity. This display, together with the physician’s remark on the patient’s last-minute concern (“that’s where the liver is”), seeks to conclude the topic of the pain (Button & Casey, 1984) and thus begins to re-negotiate a shift into the closing activity. The doctor’s nonverbal behaviors are similar to those that he exhibited during his initial shift into closing (line 139, Fig. 3) and strongly communicate that he is removing his attention from the patient and making a transition into closing (Goodwin & Goodwin, 2004; Schegloff, 1998). However, in subsequent sections of this consultation that are not included here, the patient raises a third concern regarding occasional headaches, which is initiated through another connective term, kulikwuyo, “and”. During the patient’s presenta of his concern about his headaches, the doctor steadfastly maintains his gaze on the screen and leans further toward the computer screen, thereby denying the patient any opportunity to establish an engagement framework involving mutual gaze. He later dismisses the concern by stating that headaches are a rather common symptom for people of his patient’s age, leaving the patient with two unmanaged symptoms (i.e., occasional pain below his rib bone and headaches).

In summary, the patient’s attempt to topicalize additional concerns is produced in reference to, and competitively with, the physician’s transition into closing and functions to interdict this activity. The patient’s use of the word kulikwuyo, “and”, after the doctor’s pre-closing activity ingeniously positions his proposed activity as produced in line and continuation with the medical consultation, rather than as competing with the activity of closing. However, the physician relies on embodied resources to depict the patient’s activity as interruptive and discourages a fuller treatment of the symptom. The following extract provides the ending minutes of Closing 2 which occur after the patient has finished expressing all of his concerns.

Here, the patient questions the doctor’s proposal to get an examination (“should I do that?”; line 169) after which the doctor offers a brief confirmation (“–yey, “yes”). Only after the patient accepts the doctor’s proposal (“yey kum “okay then””, line 171) and begins to rise from his seat does the doctor turn away from the computer screen to direct his body toward the desk (lines 172–173). Fig. 5 shows the positions of the doctor and the patient as the doctor utters lines 172–173.
Closing 2. SS5 (continued from above)

(20 lines omitted)

168 DOC:  kemsaa hay talla kule-si-nyen twey-cwo mwe.
           Exam do give say-SH-if do-COMM:POL DM
           Just tell (them) to give you the examination.

169 PAT:  kule-lkka-yo?=
           say-INTERR-POL
           Should (I) do that?=

170 DOC:  =yey.
           Yes:POL
           =Yes.

171 PAT:  yey kulem.
           Okay then
           Okay then.

172 DOC:  kulayse iltan yoke icye kasum x-ray sacin-man
           so first this now chest x-ray picture-only
           il-chung cikum naylyeka-sye-se
           first-floor now go.down-SH-CONN

173         pala cciku-si-kwu-yo?
           immediately take-SH-CONN-POL

→ So first go down to the first floor now and just take a chest x-ray immediately?

174 PAT:  ney.
           Yes:POL
           Yes.

175 DOC:  olla-o-sey-yo.
           ascend-come-SH-POL
           (and then) come up.

176 PAT:  ((leaves the room))

The component of the doctor's talk at lines 172–173 is recycled from the previous pre-closing sequence (“take a picture and come straight up now”, line 139), with a slight change in words (“picture” is replaced by “X-ray”). Without any verbalized terminal exchanges, the patient bows his head and leaves the office.

As explained above, when this patient presents last-minute concerns (e.g., pain below his rib bone, headache) that appear to be unrelated to the lung problem, which was the main reason for this visit, the doctor is visibly inattentive. When we focus on the embodied movement of the doctor throughout Closing 2, it becomes apparent that the doctor's gaze and body offer as resources the depiction of incipient closure of the medical visit. This phenomenon can also be explained in terms of participation structure. The doctor's bodily movement and direction of gaze establish a transition from the existing participation framework (Goffman, 1963; Goodwin, 1981) of a doctor and patient attending to one another to a doctor attending to the computerized medical record, thereby implying the conclusion of the medical consultation. These types of bodily resources communicate to the patient that

172-173 DOC: il-chung cikum naylyeka-sye-se pala cciku-si-kwu-yo?

So first go down to the first floor now and just take a chest x-ray immediately?

Fig. 5. Closing 2 lines 172–173.
additional concerns are not welcome and will not be given extended consideration at this moment in the consultation.

The two remaining examples of closings with last-minute concerns are provided below, in which patients’ efforts to bring up additional concerns are discouraged by the doctor. In Closing 3, the patient is a 5-year-old child who has a cold. The extract begins as the doctor starts to type a prescription on the computer while giving instructions (“I’d like you to take some medicine”, line 61) which constitutes a pre-closing turn. After a 0.5-s pause, the mother introduces an additional concern using kulikuwo. “and” (line 63). The doctor treats this turn as interruptive and interdicting his activity of medical record keeping by explicitly asking the mother to wait (“camkkanman, “wait a second”, line 64). After the doctor finishes typing (line 67), he turns his upper body toward the patient, which is taken as a cue for the mother to indicate the area of concern (a mark on her daughter’s forehead) to the doctor. Both with her nonverbal action and talk (“Here on (her) forehead:”, line 68), she directs the doctor’s attention to her daughter’s forehead. The relevant framegrabs depicting both parties’ body and gaze orientations are included under the corresponding transcript.


61 DOC: ca:: yak-ul ^ccccum te mok-ess-umyen coh-keyss-nunte:y, now medicine-ACC a:little more eat-PST-if good-DCT:RE-and Now:: (I)’d like (you) to take some medicine.

62 (0.5)

63 MOM: kulikuwo-yo sensing-nim:: And-POL teacher-HT → and doctor::: ((while touching child’s forehead))


65 MOM: =ye:y. Yes:POL =Yes::

66 (3.0) ((types onto computer and turns toward mom))


68 MOM: yoki ima-ey-yo:: Here forehead-at-POL → Here on (her) forehead: :

69 DOC: ney. Yes:POL Yes.

70 MOM: i-key thayenass-ul-ttay-pwuthe ilayss-nuntey? This-thing born-ATTR-when-since this:way-but This was like this since (she) was born but?

74 DOC: ccom? Iss-re-yo, cem? mm.
dot exist-FR-POL dot
A mark? It’s there. Mark? mm

(33 lines omitted)

104 DOC: yey yak-man com mek- co:kum te mek-eya
Yes:POL medicine-only a:bit eat- a:bit more eat-IMPER
twe-l ket kat-sumnita.
Must-ACC thing seem-to:be
Yes just take some med- it seems like (she) should take
some:: medicine.

105 (0.2)

105 MOM: kule-ko tto wa-ya twey-nun ket mac-cwo.
then-CONN again come-IMPER must-ATTR thing right-COMM:POL
And then (she) should come again.

106 Yey anyenghiksey-ye::
yes:POL goodbye-POL.
Yes. Goodbye:: (walks out with child)

107 DOC: yey yak-man sam-il-pwunchi cal mek-e-pwa:::
yes:POL medicine-only three-day-worth well eat-IE-try
Yes just try taking the medicine correctly for three days:::

108 CHI: an\nyenghiksey-ye.
goodbye-POL.
Goodbye[.]

109 DOC: [kulay annys::ng.
okay goodbye

[Okay goodbye::.

110 DOC: um kulay cal-ka,
yes okay well-go
Yes okay farewell,
After the doctor identifies the mark (line 68), he begins to pull back while the mother elaborates on her concern (line 71) regarding the mark’s color and size (not shown here). As in Closing 2, the doctor treats the mark as nothing serious, stating that it looks okay, and directs the patient to see a dermatologist if she is concerned. Again, after the doctor looks at the mark he begins to shift his gaze and bodily orientation toward the screen to signal disengagement from the patient. The consultation closes with a repetition of the prior treatment related future arrangement sequence (“take some medicine”, line 104) followed by a reciprocal farewell from both the mother and daughter.

In the third and final example of an additional concern being raised, the patient visits the family care department regarding a dog bite from her three-month-old puppy. After a lengthy history-taking sequence asking for symptoms, the doctor finishes examining the patient’s dog bite but does not find anything problematic.

### Closing 4. C5 rabies

175 DOC: kangaci yay-yang cepcong-ul kwuchikcukulo hanun-key
puppy flu shot-ACC regularly do-thing

te coul ket kat[enty, more good thing seem-CIRCUM

(I) think it would be better to give (your) puppy regular
vaccinations , , (Doctor flips through notes)

176 PAT: ney sensangnim ce kuli[kwu-ye:::
yes doctor um and-POL
Yes doctor um and[::

177 DOC: [ney ney. yes yes
Yes yes

178 PAT: ce cey-ka paykophu-myun mali-eyo.

Um when I’m hungry. ((Doctor maintains gaze toward note.))

(32 lines omitted)

210 DOC: kangaci-nun ku-cengto-nun salccak salccak hal-nun ken
puppy-TOP that-much-TOP little little lick-ATTR thing
kwecnchar-i ko.
Okay-CONN

And the puppy licking (your) have a little bit like that is
Okay[.]

221 PAT: [ney. ((begins to rise from chair))
yes
Yes.
As soon as the doctor suggests giving the dog regular vaccinations, the patient produces an acknowledgment (ney sensangnim, "yes doctor") that overlaps with the last segment of the doctor's turn (katentey, "seem", line 175). The acknowledgment is followed by an introduction to another problem with a slight hesitation, "um", followed by a connective term kulikwuyo, "and", which is similar to how patients topicalized additional concerns in Closings 2 and 3 above. After the doctor indicates his acceptance of the new topic with two acknowledgment tokens, neyney, "yes yes" (line 177), the patient complains about a dizziness problem that occurs when she becomes "hungry" (line 178). The doctor, however, does not remove his gaze from the memo pad he has been flipping through during the pre-closing turn. He later delivers a somewhat speculative diagnosis by stating that this symptom is a normal occurrence among people who skip meals and suggests that she always carry snacks with her. Up to line 210, the doctor's gaze is firmly fixed on the papers and notes in front of him and he only looks at the patient when he re-delivers the pre-closing turn (line 210). In this example, the doctor's desk is oriented toward the patient (this hospital still relies on paper medical records; thus, doctors rarely use the computer), making it impossible for him to engage in body torque. Thus, the doctor employs gaze to indicate that his dominant engagement is with the medical records rather than the patient. Complaining of an additional problem that has not been raised during the opening phase of the consultation is treated as a dispreferred action primarily through the doctor's nonverbal behavior of diverting his gaze and occupying himself with a separate activity.

Across these three closings, patients raise their additional concerns at similar locations — immediately after the pre-closing sequence is initiated by the doctor. Doctors respond to these concerns (→) in similar ways by employing nonverbal resources. A brief outline of the three cases may be schematized through the following five turns:

1 DOC: “Arrangement-related” business-preclosing sequence
   (e.g., Take a picture and come up now.)

→ 2 PAT: (Acceptance of 1) + initiation of new concern (connective “and”)  
   (e.g., And.)

3 DOC: Go ahead response (“yes”)  
   (e.g., Yes.)

→ 4 PAT: Presentation of an additional concern  
   (e.g., Here right below. It hurts.)

5 DOC: Evaluation and discouragement (through gaze and body movement) of  
   additional concern

Fig. 6. The organization of last-minute concerns during visit closure.
with the physician's transition into closing and functions to interdict this activity. The physician treats these additional concerns as interruptive relative to the previously established trajectory of the encounter, which was the closing sequence, through disengagement of the body and gaze (e.g., Fig. 4). Gaze and body employment contribute to the timely management of the visit as suggested by one of the two physicians who were later interviewed. Reflecting on his performance, Dr. Ryu described the direction of his gaze as partially intentional:

I used to spend more time talking with patients. The reason I spend more time looking at the computer now is because if I gaze toward the patients, they talk more. This is very important. If I talk to patients with eye contact (lit: eye-to-eye), then the patients want to talk more. To prevent this, I can't just look anywhere so I continue to look at the computer screen.

Because the Korean medical service adopts a fee-for-service structure, physician income changes in proportion to the number of patients. Thus, practicing doctors in Korea also have financial incentives to spend less time on counseling (Cho et al., 2004) which may contribute to the organization of last-minute concerns during these visits.

In summary, the closing in Korean primary-care visits is geared toward a single future arrangement sequence followed by terminal exchanges. Patients may introduce additional concerns following the future arrangement sequence and before terminal exchanges by employing linguistic resources (e.g., the connective term kulikwuyo, “and”); however, this action competes with the doctor’s closing activity. In these instances, the doctors attempt to re-initiate the closing activity by disengaging their gaze to align with their bodies, which is a legitimate action (attending to the medical record). In the following section, the results of the current paper are discussed in terms of their implications for future studies and practices.

Conclusion

The current study demonstrates that Korean medical closings consist of two phases—an arrangement-related pre-closing sequence followed by a terminal exchange—and lack a final concern pre-closing sequence in which physicians may solicit last or final concerns (i.e., Any other problems?). When last-minute concerns were raised in three out of 60 cases, in the location after the doctor’s proposal of a prescription-related future arrangement, doctors in the current data set were observed to redirect their gaze and body orientation from the patient to the computerized medical record, thereby working to maintain a quick progression to closing. The patient, seeing how the doctor responds, allows the doctor to not pursue the projected matter and abandons further discussion. Through this negotiation, the patient and doctor re-establish the alignment toward the original trajectory of the visit and the last-minute concern fails to engender further inquiry or diagnostic significance. In these contexts, therefore, it is rare for the patient to verbalize additional concerns.

These findings are striking given that, in the Korean medical context, openings begin with a one-problem question (Park, 2009; Where does it hurt?) and the most relevant location for patients to topicalize additional concerns (after the opening) is during the pre-closing environment, when a negotiation and transition into the activity of closing begins (White et al., 1994, 1997). This study confirms that patients have difficulty raising additional problems, which is evident by the lack of its overall occurrence in the entire data set (7%). The lack of an opportunity to raise additional questions is an important issue to consider in future medical education programs because there are apparent drawbacks to having patients leave the hospital (or clinic) without being able to present additional and unaddressed problems. A growing body of literature also shows that patient participation is associated with better health outcomes (Griffin et al., 2004; Kaplan, Greenfield, & Ware, 1989; Ward et al., 2003). On the surface, the Korean medical consultations examined in the current study appear to be highly efficient; the visits are brief, one concern is attended to, and the patient visibly and efficiently coordinates the closing with the doctor (Closing 1). The analysis showed that this type of tight interactional organization is initiated and maintained by doctors through their use of gaze, body orientation and talk, together with the patient’s collaboration in the closing activity.

The visible, professional use of the body engaging in the activity of putting down the information as well as providing results can give the impression that the problem of the patient is taken seriously (Berg, 1996). However, as shown here, the same practice can prevent the patient from presenting additional concerns in the closing environment. If physicians want to maximize the potential for patients to raise additional concerns, they should halt competing activities (e.g., gazing at the medical records), orient their bodies and gaze toward the patients, and employ final concern questions such as “Do you have something else to talk about?” that require an answer related to new concerns (Heritage et al., 2007). Additional research is needed to be involved with (Heritage & Kaplan, 1999; Stewart et al., 2000) provide evidence that patient-centered practices require little or no extra time when compared to doctor-centered practices. Heritage et al. (2007) also showed that allowing patients to finish presenting their problems did not significantly affect the visit length. Future studies in the Korean context may investigate whether different question designs affect the way in which unmet patient concerns are raised as topics for discussion. In addition to this question, the results of the study strongly suggest that future medical training programs should include the use of embodied resources in the closing minutes as a topic of discussion. In physician—patient interaction, physician nonverbal communication (eye contact, posture, nods, distance, communication of emotion though face and voice) have also been reported to be positively related to patient satisfaction (DiMatteo, Hays, & Prince, 1986; Larsen & Smith, 1981). If gaze does indeed contribute to a fuller disclosure of patient medical problems and the identification of emotional illnesses (Bensing, Kerssens, & van der Pasch, 1995; Mast, 2007) without affecting visit length, physicians and patient would greatly benefit from being trained to establish eye contact.

In the three instances in which patients raised additional concerns, which were subsequently discouraged, the physicians were male and the patients were either female (2) or male (1). For the single consultation in which the physician asked “Do you have another problem?”, both the physicians and the patient were female. Initially, it appears that gaze and movement patterns may be interpreted with reference to cultural conventions regarding inter- and intra-gender relations. Because of space constraints, however, issues concerning gender relationships have not been considered in the current analysis, although the issue of how physician gender may influence the interaction trajectory would merit further study.

Finally, this study has implications for the use of gaze in different cultural backgrounds that are expected to diverge to some degree, especially in terms of how gaze is used and attended to. It is popularly believed among Western observers that Asians tend to avoid direct eye contact in face-to-face interactions (Dresser, 2005). For example, Axtell (1993) claims that Koreans avoid prolonged eye contact because it is considered to be impolite and intimidating. Studies on medical communication show that physicians of Asian descent displayed less positive affect than black and white doctors and reported that non-white patients demonstrated fewer self-initiations relative to white patients in a lung cancer setting as...
rated by observers (Street, Gordon, & Haidet, 2007; Street, Gordon, Ward, Krupat, & Kravitz, 2005). Although popular beliefs, anecdotal self-reports and quantitative research suggest differences exist between American and Korean gaze practices, these nonverbal behaviors need to be tested empirically. A rigorous micro-analysis of video recordings of real-time conversation episodes in the present study indicates that the use of gaze and body orientation by Korean physicians and patients cannot be easily generalized into a simple cultural pattern.

In Korea, children are frequently scolded by adults for looking directly into the eyes of their elders or their teachers while they speak. People who are older or in a higher position in society also avoid direct eye contact with younger peers, siblings, and employees (Axtell, 1993). However, the current analysis shows that the gaze and body practices of Korean doctors’ and patients’ communicate the same functional uses for which gaze and the body are employed among doctors and patients in Western medical contexts (Heath, 1986, 2002; Ruusuvuori, 2001). For example, doctors in Korea use body torque and gaze removal to demonstrate disen- gagement regardless of their age or gender, which is similar to Korea use body torque and gaze removal to demonstrate disen- 

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References
