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Autor: Moreira, Tiago

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Involvement and Constraint in a Surgical Consultation Room[1]

Tiago MOREIRA
Lancaster University, Centre for Science Studies, Dept of Sociology,
UK-Lancaster LA1 4YN; t.moreira@lancaster.ac.uk

Cet article décrit différents parcours interactionnels pouvant caractériser une consultation chirurgicale. Il montre comment la décision d'inclure ou d'exclure le patient dans le traitement chirurgical est structurée par la façon dont les participants organisent leur engagement dans l'interaction. Les différents niveaux d'engagement résultent du processus à travers lequel le chirurgien et le patient ajustent réciproquement différentes ressources matérielles et sémiotiques, ainsi que de la façon dont ces arrangements affectent leur compréhension morale de la situation.

Sur la base de matériaux ethnographiques recueillis dans une clinique neurochirurgicale portugaise, l'article se focalise sur quelques séquences interactionnelles observées durant la consultation chirurgicale. Comme les participants déploient et ajustent mutuellement leurs ressources, celles-ci ont pour effet à la fois de faciliter leur engagement et de contraindre la suite des événements. Dans la construction de ces trajectoires chirurgicales, le déroulement des interactions va de pair avec la négociation par le personnel médical et le patient de leur orientation mutuelle.

In this paper I describe how interactive pathways performed in the consultation room of a neurosurgery clinic affect the inclusion of patients in, or their exclusion from, surgical treatment. In the consultation room, surgeons and patients try to determine, with the resources available at hand, whether a particular condition is suitable for surgical treatment. These interactions are organised by talk, gestures, body orientation and display, interpretation of written and radiographic materials and the material setting in which the interaction takes place. The outcome of the consultation depends upon the way in which the juxtaposition, that is, the mutual adjustment of these material and semiotic resources unfolds in particular interactions[2].

It is my suggestion that different outcomes correspond to different degrees of *involvement* achieved in the interactions. Goffman's notion of involvement captures the kind of cognitive and affective engrossment participants are morally expected to display in particular situations (see, especially, Goffman,

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2 For a different analysis of these processes of juxtaposition, see Goodwin, 2000.

1963, pp. 33-79). For him, situations structure the immersion of participants by «framing» their activities. These frames stipulate what kinds of objects and events are «in» or «out» of the situation[3]. Within the situation, there is also an ordered set of events and roles to be performed and a range of relevant differences between people and objects to be attended to. From this point of view, the involvement of surgeons and patients in consultation rooms is configured by the «frame» and the moral and procedural rules concerning «consultations» as a special type of social gathering. For Goffman, each type of situation entails a specific form of involvement.

The types of gathering and their different implications are recognisable by competent members of a society. For such actors, the identification of and compliance with the rules of a situation is unproblematic. In this sense, Goffman's method of identification of gatherings and their activities is formalist, because it does not take into account how the ways in which matters are dealt with in interactions might affect the structure of the interaction and its prescribed level of involvement. As Wes Sharrock (1999, p. 131) has argued, it is immaterial for Goffman's enquiries how the content of those gatherings is managed and organised by those involved in it. However, participants' organisation and the correlated understanding of situations is crucial in structuring the moral and cognitive «frame» of their activities. Involvement, in this sense, can be seen as an accomplished, and problematic, feature of social interactions depending on how actors articulate the relations between the heterogeneous material and semiotic resources within their activities and intersubjectively adjust to these arrangements[4].

In order to explore the dynamics of this process of mutual adjustment and its consequences for involvement, I draw upon Michel Callon and Vololona Rabeharisoa's (1998) notion of reconfiguring trajectory. This notion will allow for the re-description of ethnographic data gathered in surgical consultations as uncertain and non-linear processes of formation of surgical *patient collectives*. A patient collective is defined as a composition of bodies, competences, artefacts and emotions gathered together by a particular activity

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3 «Frame (...) organises more than meaning; it also organises involvement. During any spate of activity, participants will ordinarily not only obtain a sense of what is going on but will also (in some degree) become spontaneously engrossed, caught up, enthralled. (...) Involvement is an interlocking obligation.» (Goffman, 1974, pp. 345-346).

4 I am borrowing here Myriam Winance's use of «material and moral adjustment» (Winance, 2000).

or interactive exchange between participants. It is an intrinsically dynamic notion.

Deriving from Michel Callon and John Law's definition of hybrid collective as an arrangement of heterogeneous materials activated by a particular endeavour (Callon and Law, 1995; Callon and Law, 1997), the notion of patient collective denotes both an alternative to a structural and a situational conception of agency. Despite their differences, both these conceptions consider that the material environments in which action is located are simple constraints or resources to be used by the human collective (society or group). In their papers, Callon and Law argue instead that materials (technical devices, written papers, measurements, architectural settings, etc.) partake in structuring the flow of activities in which humans are engaged.

In reconfiguring trajectories, the relation between materials established by such exchanges is linked to previous arrangements relating to the same collective, albeit not determined by them. The pathway traced by succeeding arrangements delineates a trajectory. By describing the trajectories of interactions in the consultation room it is possible to understand involvement and its interlocking obligations as outcomes of sequences of materially embedded activity. It is also possible to understand how patient collectives are constructed in surgery and become (or not) surgical collectives.

In line with this orientation, I argue, furthermore, that the dynamic adjustment of material and semiotic resources imprints upon the delineation and the understanding of the various components of a patient collective. The activities of participants in situation structure the relationship between the resources available for them to use. As surgeons and patients collaboratively construct the constituents of the collective, these elements constraint and facilitate the participants' involvement[5]. In failing to accomplish these outcomes, in failing to align constituents with each other, participants become, in effect, progressively detached from each other. My interest is in understanding how the symptoms, descriptions and «objects» constructed and/or used in interaction can become sources of moral framing, constraint and facilitation, that is, of involvement.

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5 I emphasised the collaborative aspects of these activities in favour of the different «power positions» arranged in these processes. This was because the aim of the paper is to suggest that the situated, interlocking moral obligations experienced by actors are embedded in dynamic processes of material and moral adjustment. Our mundane orientation towards each other is negotiated through material mediations (Latour, 1996). I used the case of involvement to illustrate this argument.

Methodology

The two cases explored in this paper illustrate two of many different possible trajectories of patient collectives in the consultation room: in Case 1 the patient is accepted in the clinic; in Case 2 the patient is rejected. Both patients present very similar symptoms, those associated with compression of the spinal nerve roots by a prolapsed spinal disc. These two cases exemplify how opposing levels of involvement can be accomplished in dealing with very similar conditions. The data was gathered by direct observation of interactions taking place in the consultation room of the neurosurgery clinic where I developed ethnographic fieldwork between 1998 and 1999.

The neurosurgery clinic is integrated in a university hospital located in Lisbon, Portugal. The clinic is directed by a prestigious neurosurgeon who did most of his surgical and scientific training in the United States. Most consultants or registrars have, at some point of their careers, undergone some kind of surgical training abroad. Both because of the clinic's reputation and the national health system's spatial organisation, patients are referred to the clinic's surgical consultants by GPs and other consultants (neurologists, psychiatrists, orthopaedists) practicing in an area radiating various miles around Lisbon. The consultations take place every Wednesday morning, a time slot where surgeons have to fit a considerable number of patients.

The empirical materials presented here are reconstructions of the interactions observed in these surgical consultations. During fieldwork, I would sit in consultations whenever patients authorised my presence (which they would be asked for, informally, by the surgeon, before the consultation started). During the consultations I selected particular utterances that would become the basis of my re-description of the situation afterwards. For the purposes of this paper I have translated the original fieldnotes from Portuguese to English. The names of the patients, their relatives and surgeons are aliases.

Because my argument maintains that involvement is accomplished differently by divergent interactive pathways, I will dedicate special attention to the interpretation of the sequences of activity observed in both cases. It is this explication of the unfolding of relationships between bodies, objects, talk and setting that will help identify the trajectory crossroads presented to patients and surgeons in neurosurgical consultations. These explications of the sets of activities will further detail the activities, both ethnographically and analytically.

Case 1

After giving her name and details to the secretary, Mrs. Branco waited on one of the stools of the waiting room. Despite the fact that the television was unusually loud that morning, she heard her name being called and summoned her relatives to help her to get up and walk to room 3.

The three women came into the consultation room; the oldest being helped by one of the other two. She sat next to Dr. Soares and me. She looked anxious and sad. Dr. Soares broke the silence, by asking her name.

– Maria Branco

He introduced himself to her and they shook hands. They then talked about how difficult it is to get through the traffic at this time of the day. Dr. Soares smiled and changed topic:

– ...so, what brings you here...?
– It's this pain in my left leg; I can hardly walk.
– She can hardly walk, echoed one of the younger women.
– And you are?, Dr. Soares asked.
– We are her daughters...
– Hmm, he muttered.

They then had a small conversation about Mrs. Branco's life: she was a widow; housewife; had been feeling this pain for a while whenever she did her house chores; had a vegetable garden and some chickens.

– Ok, what I want now is to know more about that pain of yours: does it go all the way through your toe?, can you say on a scale of 1 to 10 how much does it hurt?

Although Dr. Soares is a young surgeon he specialises in spinal surgery; and he seemed to expect all the answers given to his questions. He wrote down the answers given by the mother and her daughters even though some of them seemed very vague to me ("sometimes its just like a tingling sensation...", was one of Mrs. Branco's answers)

He then asked for the "x-rays" Mrs. Branco was holding in her hand. He looked at them against the light coming from the window behind us. He pointed to the Computerised Tomography (CT) scans and identified something:[6]

– ...prolapse..., he said.

He explained this to Mrs. Branco:

– It seems that your spine is compressing your nerve roots and that that is what is causing you pain and the tingling...

He got up and asked Mrs. Branco to accompany him to the next room. With his hammer he tapped Mrs. Branco's knees, back of the feet and rubbed her foot sole. This took about two minutes, in which Mrs. Branco and Dr. Soares tried to get to the best body arrangements to achieve the tests Dr. Soares wanted to perform. They returned to the room where the rest of us were.

– ...could you see the difference between your left and right legs?, Dr. Soares was asking.

Mrs. Branco looked at him in agreement.

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6 Computerised tomography is a X-ray examination technique in which body structures are visualised according to particular planes. These images are the result of differential absortions of X-ray beam by a detector, which are then processed by computer and turned into images of «slices» of body.

They sat down again. After a moment of silence in which he compared the various CT scans, he addressed both the mother and the daughters and said:

– I am prepared to operate, but I must tell you now, it will only partially solve the walking problems. You, your mother will be able to walk better and for longer distances but the intervention won't put her back to normal.

The mother and daughters looked at each other.

– If you say that it is to operate...
– What I say is only part of it, the question is, do you want us to stab you in the back?, asked wittily Dr. Soares referring to the procedure of laminectomy in which the patient is effectively cut open in the back.

Mrs. Branco did not answer.

– It is *your* pain, with which you have lived for a while, so the question is can you continue like this?
– ...no...
– ...so...?

Another silence followed, a long one.

One of the daughters then asked what the operation was like. Dr. Soares went through a brief narrative of the procedures of laminectomy:

– we open the spine and release the pressure...,showing with his finger and the CT scan what would be the approach they would take.

Their indecision was obviously making him impatient. He fiddled with the appointment cards of his next patients. Recognising this, Mrs. Branco started to talk:

– It's that I've never been operated on...
– ...you're a bit scared..., Dr. Soares interrupted
– ...yes...
– ...there is nothing to be scared about, but I understand, this is a simple procedure, probably one hour...

After another silence, Mrs. Branco agreed to the operation.

– I'll put you on the waiting list, when we have a space the secretary will call you...and we'll go through more details.

Case 2

Mrs. Rebelo was told to be in hospital at nine o'clock. She didn't want to come. She hates hospitals. She hates the waiting rooms and their noise and confusion. They disturb her. She told me that she knows about hospitals. She also told me that she was nervous about not knowing the surgeon she was meeting. She was visibly nervous.

She was called into room 5. In there, Dr. Castanho was reading her file when she got in. They exchanged names and Mrs. Rebelo sat down. She immediately started telling Dr. Castanho what was the reason for this appointment.

– ...at the end of my back, this pain and numbness, both sides...!

Dr. Castanho was taken aback by this. He picked up the CTs that the secretary had left in his table.

– What?, she asked.
– Well, there seems to be a protrusion in some of your lumbar discs...
– ...what does that mean?!

– ...both sides of your roots are being compressed...
– ...do I have to be operated?
– ...er...I don't know yet...

Dr. Castanho tried to slow down the interaction by re-reading the file.

– ...the best is for us to do some tests and see...

He got up and asked Mrs. Rebelo to accompany him. He asked Mrs. Rebelo to walk on her toes and then on her heels. She tried and failed to do this various times. Dr. Castanho tried to teach her how to do this by doing it himself, but Mrs Rebelo could not do it. He tried then to test some reflexes on the back of her legs and feet. Mrs. Rebelo started crying. He stopped and asked Mrs. Rebelo to sit down again.

– I can see that you're very nervous...

Mrs. Rebelo didn't even answer. Dr. Castanho waited. When Mrs. Rebelo had calmed down he asked her if she wanted to do this some other time. He explained that he was prepared to do it in a more private space. She agreed. And left.

One week later, Mrs. Rebelo came in again. It was almost lunchtime and most of the consultations were over. She looked calmer.

– How are you doing?, Dr. Castanho asked.

She apologised for her behaviour in the last appointment:

– Its my anxiety...
– I know..., said Dr. Castanho, obviously avoiding to talk about Mrs. Rebelo's depression, about which he had been informed after their last appointment.

However, he had to ask:

– Have you been taking the pills that Dr. Antunes prescribed?
– ...yes...
– ...good.

There was a long silence, after which Dr. Castanho got up and suggested that they should try the tests again. Mrs. Rebelo agreed. But they again failed to perform those tests, and Mrs. Rebelo was again visibly disturbed and emotional.

– Maybe I am using too much force with the hammer..., said Dr. Castanho.

But this was not what he was actually thinking:

– Mrs. Rebelo, I have to be open with you, without these tests I cannot evaluate the degree to which your nerve roots are debilitated... and without this we cannot...
– ...I know, I'm sorry...
– Probably you should come in when you feel ready for it, I can open a space to go through this with you, it will only take five to ten minutes...
– ...yes...

However, I didn't see Mrs. Rebelo again. When I asked Dr. Castanho about her, he said:

– I'm sure surgery is the last thing she needs at the moment, I cannot do anything for her now...

In the following sections I will elaborate upon the ethnographic case stories by explicating the structure of the sets of activity presented to surgeons and patients engaged in neurosurgical consultations at the clinic. These sets of activity are: the arrangement of a «surgical case» to be presented to the

surgeon; the description of the socio-material environment in which the patient's complaint is to be understood; the construction of an agreed representation of «disease»; and the exercise of forms of judgement. In which of these «frames» participants negotiate their immersion in the activities and their position in relation within the patient collective.

Bringing a «case» together

As a patient, the first contact one has with the surgical department is through the secretary. One arrives at the clinic and announces one's arrival, the appointment is checked, the secretary asks for the national health system number and, if it is one's first appointment, as was the case with Mrs. Branco and Mrs. Rebelo, the secretary fills in a computer file with name, address, phone number, name of close relatives, profession, etc. Those details will come up every time the patient has a new appointment and will be used throughout her treatment, for contacting relatives in case of emergency, and for making sense of the patient's position within the health system (does she have health insurance?) or in relation to other institutions (work, etc.).

Once the administrative details are filled in, the file is printed and taken to the consultation room. This file has various «medical documents» attached to it: a letter from another doctor explaining why s/he thinks the patient should be seen by a neurosurgeon, tests concerning the suspected condition of the patient, etc. In reading the file, the surgeon selects, in advance, the type of problems that the patient might present in the consultation room. This activity distinguishes between types of consultation (first, follow-up, surveillance) and possible type of condition (spine, peripheral, cerebral, neoplastic, etc.) in which to insert the interaction that is about to happen. At the same time, in the waiting room, the patient is holding a card with the name of the doctor. In this period, it is also usual to hear patients asking other patients about doctors, about how they are, how old they are, etc.

Outside, in the waiting room, all patients are equal. They are equally engaged in this process of constructing the best possible bid for surgery[7]. The secretary warns them that if they do not have the CTs scans or some other element for

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7 Biding is here used as a metaphor for the activities in which patients engage before the surgical encounter. Patients arrange their stories and their «files» in order to obtain attention from a surgeon; this is understood by the surgeon, who manages his attention as a scarce resource. This situation can be likened to a market, in which patients offer a certain good (the case) in exchange for another (attention).

their file, they will have problems with the surgeon: «Dr. X does not like to see patients without their tests, there is not much point, you see». This means that they are put into competition for the attention of surgeons. The bureaucratic re-arrangement of patients' collectives is justified in terms of surgeons' labour time, in the sense that a neat file, with all the elements in the right places, saves a lot of time in the consultation room.

The tasks of managing and arranging this collective, which started well before the patient's appointment, have some continuity with the types of requests patients encounter when they arrive at the clinic on the day of their appointment. The process of construction of the administrative file is partially supported by the database system used in the hospital. However, and I would say equally important, it also implies that patients have their identification cards and can remember things like the name of their GP or their post-code. These activities structure the understanding of the encounter and of the type of involvement required in it.

The activities of gathering and stipulating materials for the actual encounter with the surgeon repeat themselves every time patients come to the neurosurgery clinic. As the patient is presented to the surgeon, the purpose and the bureaucratic frame of their encounter is already defined. This implies that there is a form of organisation of files that is specific to neurosurgery, in the sense that it depends on envisaging particular relevancies of the surgical consultation that are not actually present either in the waiting room or in the various settings patients and/or their relatives come across before their appointment.

These activities of arranging the file, reading it and waiting correspond to a pre-figuration of the actual encounter between the surgeon and the patient. It situates the patient collective as a «request» for surgery, both for surgeons and patients. In this set of activities the collective is configured as looking for a «surgical forum», a place where the patient's complaints can be tested against the requirements of surgery. This selects the problems that can be voiced in that forum and elaborates the problems the patient wants to talk about to the surgeon, as well as gives the surgeon a specification of the situation he is about to enter.

The differences between Mrs. Branco and Mrs. Rebelo illustrate how this relationship between activities and involvement can have diverse outcomes. While Mrs. Branco patiently waited in the waiting room for her name to be called, Mrs. Rebelo expressed apprehension and anxiety about the medical

encounter. Mrs. Rebelo's was disaffected from the aims and purposes of what was being done for her and by her to arrange the meeting with the surgeon. She experiences these arrangements as an imposition, a veritable restriction of her will. Mrs. Branco, on the other hand, accepts the requests and limitations imposed on her by the bureaucratic organisation of the clinic and understands their role in facilitating the encounter with surgeon. These two different positions within their patient collectives have consequences on the way each patient comes into the next set of activities.

Getting to know the patient

The patient is called into the consultation room. The first element both the patient and the surgeon confirm is their identities, either by recognising them or by explicitly asking. This being done and established, they move on. They move on to a more social level. Dr. Soares and Mrs. Branco talked about traffic. In other encounters, I have heard people talking about the weather and similarly trivial topics.

But they are there to talk about a «problem». The problem already had a name. A name that is, in a certain sense, already «surgical», or better said «probably surgical». The bidding attitude continues. The patient is asked to present her case in a way that would suit the situation: «What can I do for you?». This opens the discussion in the forum of the consultation room. The patient, or a relative, voices a complaint. Some patients even give the surgeon the name of the disease: «It seems that I have a disc prolapse...». Surgeons take this as a claim for surgery, as configured by the patient and her other doctor(s). That is, they have to determine if this person is right for surgery. In surgical consultations, a person is constructed as a complex being.

A person has relatives. Some are present in the consultation. It is good to know, for instance, that patients have a support network and that they are not going to be alone in the anxieties and fears that precede surgery and the pain and body re-adjustments that follow it. This takes work off the shoulders of surgeons, nurses and social workers. A person also has a «way of living». A profession. A house. A life with its own material and moral conditions. These are all relevant constituents of the configuration of the patient as «person».

Take the case of Mrs. Branco. She was a housewife in a house with a vegetable garden, which in Portugal, means that she is probably responsible for a lot of the work done in the garden during the day. This work can be quite heavy and involves lifting heavy weights and carrying loads. Being a widow for

a few years, she was now probably fully responsible for house management. This and her age were probably the conditions leading to lumbar disc prolapse. A person also has a particular way of relating to others. This was readily available, for example, in the way Mrs. Branco interacted with the doctor. And gives clues into the way that person is dealing with the material and emotional consequences of her condition.

In surgery, a complaint has to be contextualised in the person's life: through a person's relationship with her social, material and emotional environment. These materials and exchanges between materials detail the patient collective. This happens through a possible link between the story the patient is telling and similar surgical cases that the surgeon has heard from patients or other surgeons (either informally or in texts). In the event of this link being performed, the surgeon feels compelled to investigate the case further. The importance both of this interaction order and of the materials relevant to these descriptions can be observed, negatively, in Mrs. Rebelo's case.

Her case presents remarkable discrepancies. The interaction between surgeon and patient was problematic from the beginning. It started with the fact that they could not introduce themselves properly to each other. The surgeon did not ask about Mrs. Rebelo's life. Mrs. Rebelo did not wait for the surgeon's cue into any kind of conversation. She gave an account of her pain. Uncontextualised, this account left the surgeon looking for what to ask. For this reason, he took time looking at the patient's CTs. Presumably, Mrs. Rebelo felt that she was being left out of the «picture», seeing the surgeon silently looking at the CTs she had brought with her. This again threw the surgeon aback.

Brought together, through the hospital system, with a surgeon, Mrs. Rebelo was expecting to be given a decision about her operation on the basis of her CT scans and the fact that she felt pain. There was no sense of her relationships, her life. Her pain was unrelated to other circumstances. By not collaborating in this reconstruction of Mrs. Rebelo's life, patient and surgeon remain unconnected. Without the construction of this story, Mrs. Rebelo and Dr. Castanho cannot share anything. The collective remains an arrangement of files and paper and letters: it tells them why they are meeting but it leaves it up to them to develop other links. The refusal to develop the links of the collective, by describing it and displaying its forces, left both surgeon and patient in a situation where it seems that the collective is *indifferent* to them. It

was made somewhere else, in another doctor's room, in the hospital's central office. It is elsewhere.

Doing disease

The implication of the surgeon, through the description of materials and relations relevant to characterisation of the patient's complaint, brings a new force into the collective. It is as if, now, surgeon and patient share the burden of constituting the collective. The surgeon asks questions about the bodily manifestation of the complaint and the patient or relative try their best to give an exact description of the symptoms.

Compared with other patients I can say that Mrs. Branco was a particularly good describer of her own pain. She could tell its pathways and extension, she could relate intensity with different everyday activities, she could animate the mutability of the pain with her body: «sometimes its just like a tingling sensation», she said while demonstrating the position and feeling of the sensation with her fingers in front of the soles of her feet. The focus in accuracy characterises this exchange between surgeon and patient and continues with radiological interpretation.

In Mrs. Branco's case it was easy to identify the differences between disc structures. One could see that a set of discs near to the sacrum had a disparate morphology from those above. Normally, Dr. Soares shows this to patients. Whether because she recognized what Dr. Soares was demonstrating or because she accepted his word for it, she agreed that there was a link between her pain and the radiological images. This implicit or explicit agreement is central in structuring the participants' involvement in the situation and their attachment to the descriptions produced in it.

The interaction that followed this agreement relied on a tight coordination between the surgeon's and the patient's bodies. Dr. Soares tapped and rubbed various parts of the patient's body with the hammer, while Mrs. Branco was told not to obstruct the reactions of her body with her mind. This withdrawal from controlling one's body allows the «nerves» to come forward and display their behaviour. In confirming that Mrs. Branco had realised the disparity of reflexes between her left and right legs, Dr. Soares added another shared element to their interaction. This realisation can be seen as the last «test» through which Dr. Soares puts his patient, and takes both surgeon and patient into another mode of interaction.

Mrs. Rebelo's case is different yet again. Dr. Carvalhosa's suggestion that they should «do some tests», after they have failed to bring together a description of her life, can be seen as another of the surgeon's attempts to connect their intentions and aims in this situation. But Mrs. Rebelo could not comply with his requests. Asked to walk on her toes, she kept falling back on her heels. Asked to relax and give way to her body, Mrs. Rebelo displayed emotions instead. In this situation, they were left with a scattered collective: there was Mrs. Rebelo, her pain, Dr. Castanho, the hospital, her description of the pain, images, and a link between the description of the pain and the images. And this was not enough to compel either the patient or the surgeon into another arrangement. Her body was expressing her anxieties and standing between them. Separating them. Separating their bodies.

Faced with this, Dr. Carvalhosa chose to re-centre their interaction around the reason for their failure to perform reflex tests. As usual when these situations happen, the surgeon prefers to defer the appointment to another time. This deferment is supposed to give time for the patient, through means outside the consultation room, to come to terms with the requirements of surgical consultations.

At first, this seemed to have worked for their second appointment. She waited for cues from the surgeon and even apologised about the last time. By asking about the pills another doctor had prescribed, Dr. Carvalhosa displayed a knowledge of her situation that contextualised his understanding of her behaviour. This also, and perhaps more importantly, defined the situation they were experiencing as dependent on the medication she was supposed to be taking and as somewhat unrelated to the concerns that have been the reason for such medical action. This difference was asserted by Dr. Carvalhosa when he started once again the sequence of neurological tests.

As it turned out, that preparatory work was ineffective in trying to bring Mrs. Rebelo to a position where she could emotionally sustain the violence of reflex tests. She was again unable to suspend her engagement with her body. For Dr. Carvalhosa, even thought he partially blamed himself, this meant that they could not go on with the surgical consultation.

These two outcomes have consequences in the way participants position themselves in their patient collective. The creation of a disease in the consultation room has the possible effect of reconfiguring the patient collective from a bidding stance to one where it is being propelled, affected by something that is both «inside» and «outside» the collective: the patient's

disease. The demarcation of the patient's collective results from the way both surgeon and patient to experience the situation as framed, bounded by the representations used to describe the disease. In failing to delineate the disease as such, their interaction becomes ill-defined. Neither patient nor surgeon can mobilise cognitive or affective resources to fit the situation.

Surgical forms of judgement

A successful bid for surgery is one in which the collective creates the conditions for a particular type of judgement. This judgement may express itself in many ways. It can be expressed by the surgeon displaying himself as «prepared to operate». In this case, the surgeon may feel obligated, affected by the «pain» constructed both him and the patient. But this is open to negotiation. Take Mrs. Branco's case. In her case, the way the surgeon is affected by the collective is not enough for the patient: she wants to know what the operation entails. If, in the beginning of their interaction, the patient's pain was taken as a claim for surgery by a sceptic surgeon, now the surgeon's proposition encounters a similar defensive individual in the patient.

It is important for the patient to be able to visualise her body in the intervention, as it configures the position one should take in the consultation room. It is also important, and for the same reason, for the surgeon to understand how the patient copes with this positioning. Mrs. Branco's reluctance was defined by Dr. Soares as «fear». Most patients in the clinic expressed the kind of fear Mrs. Branco was displaying as an ambivalence between wanting to be operated on and being protective of their bodily integrity. This kind of fear was manageable in this situation by simplifying the character of the operation in terms of duration, amount of this type of operations done in a month, etc. These are the same terms through which patients and their relatives evaluate the gravity of surgical conditions[8]. But these are also the terms used by surgeons to informally evaluate working loads.

In the end, they decide that the scenario offered by Dr. Soares is a good one to agree upon. Mrs Branco will wait in her house for a phone call from the clinic's secretary, until there is a space where she and Dr. Soares can meet. She will wait. And this waiting is the only result she will get from this

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8 «..he was in there for six hours, I was starting to get worried», I heard once one patient's relative say to another relative.

interaction, a result to which Mrs. Branco can conform, or not. She can either make that waiting, or refuse to wait.

Mrs. Rebelo's case, on the other hand, does not afford such an outcome. The surgeon, Dr. Castanho, considers that the patient is not ready for surgery. He closed the consultation by indicating what her state of mind should be if she wants to come back. Later, he gave an explanation for what he saw as Mrs. Rebelo's resistance to surgery: other problems currently were more important for her. This judgement can be seen as a form of describing their failure to construct Mrs Rebelo's disease, to detach the disease from the complaint expressed by the patient. The reason why Mrs. Rebelo was pushed outside surgery had to do with the failure to attach their bodies to each other in a collective arranged around a «disease».

This connection depends upon their ability to temporarily abstract Mrs. Rebelo's pain or disease through their actions and into a story. Without assembling particular relationships between emotions and things, between lives and materials, bodies and objects, it is impossible to «project» a surgical collective into a common narrative. It is impossible to create it. As a forum, the consultation room depends upon this reflexive ability to establish visible connections between those materials. That visibility corresponds to the force of their involvement and is expressed in the form of the surgeon's decision to operate.

The concatenation of involvement and constraint

Observing the different shapes and configurations of collectives that are produced in and around the consultation room, it is fair to say that the most striking difference is between the patient collective that became «surgical» and the one that did not. In socio-material terms, the reconfigurations that go on in the consultation room have to do with the organisation of involvement. Involvement can be seen as *the organising force* in constituting patient collectives in surgery.

The construction of surgical collectives is achieved to the extent in which patient and surgeon and other participants can develop the links of the surgical collective through four sets of activity: the arrangement of a file; the description of the relevant emotional and material links to the patient's «complaint»; the construction of an external constraint to their interaction; and the exercise of forms of judgement. The structuration of a surgical collective

relies, thus, on the maintenance and management of involvement between participants in all of these forms of interaction.

The importance of managing involvement in medical interaction has been stressed by many ethnographic studies of medical encounters (Have, 1995)[9]. In such studies, however, each set of activities is studied on its own. The openings and closing of each «frame» are thought to be interactively achieved by doctor and patient through their utterances and body movement. It is a question of the participants' reflexive management of their interaction. From these studies it is also possible to understand the importance of participants' management of their interaction in determining the required level of involvement for each specific activity. Involvement emerges as a process dependent on the matters being negotiated in the interaction.

Less attention is given in these studies to the power exerted by the shape of those matters once constructed by participants. If it is true that activities delineate and construct their «objects», it is also reasonable to argue that these «objects», in turn, organises the unfolding of the interaction and the organisation of activities (Latour, 1996). Here, I want to suggest that the links between sets of activities depend, in addition, upon the participants' ability to construct the arrangements of material and semiotic resources which, once constructed, enable them to act or interact in specific ways.

The maintenance and management of involvement relies on this continuous oscillation between the making of an arrangement of materials (a structure) and the enjoyment of the possibilities for action afforded by such an arrangement. From this perspective, the establishment of each configuration of the collective leads to «an opening» into another form of interaction.

Emilie Gomart and Antoine Hennion in their paper «A Sociology of Attachment: Music Amateurs, Drug Users' (Gomart and Hennion, 1999) propose that, in analysing subjectivities, the focus could be shifted from «performance» (what and how is produced) to «event» (what arrives). Describing how both music lovers and drug addicts go through a careful construction of socio-technical apparatuses in order to receive and be influenced by their unexpected effects, Gomart and Hennion question foundational oppositions of sociology and other human sciences such as

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9 For a studies emphasising «involvement» see, for example, Heath (1986) and Pilnick and Hindmarch (1999).

agent/structure, action/passivity, free/determined, etc. (Idem: 220). With this they suggest that:

> the network is not a black pool in which to drop, dilute, criticise and lose the subject. It is on the contrary an *opening* (...) which releases us from the insoluble opposition between natural determination and human will. (Idem: 226) [emphasis mine]

They are generous enough to extend this «us» to the experts of the practices studied. As the analytical concept of network can be made to open the debates from the oppositions that, in Gomart and Hennion's opinion, have kept the «course of the world» away from sociology, so too the «dispositifs» laboriously constituted by the actors in their studies open new possibilities of involvement with the materials they love. For music enthusiasts and drug users, their «passion» needs thorough preparations for their «action» to be determined. I suggest that a similar process of *determination* and *production* takes place in the surgical consultation room.

In constructing the bureaucratic file, the various participants (GP, nurses, admin. personnel, patient, surgeon, etc) reduce the range of possible events and objects to be considered in the surgical encounter. In these activities participants actively «frame» the interaction and format the patient collective by listing the objects and events of the collective and their relations. Through these constraints the collective and its possible forms of reflexive elaboration (the consultation) come into a facilitated relationship. This relationship depends, though, on the patient and surgeon permitting its determinations to take place and direct their involvement.

The bureaucratic file contains the resources upon which participants build to initiate their interaction. The set of activities in which patient and surgeon re-describe the patient's emotional and material environment is, however, more than an addition to the bureaucratic collective brought together before their appointment. The narrative of the patient's life is specifically linked with the type of «complaint» exhibited by the patient. The materials and emotions that are brought into this description are collaboratively selected and outlined. In order for this description to determine the participants form of involvement it is necessary that both participants experience the descriptions as «shared». Such mutual understanding of the resources of the collective as instantiated in the consultation room will prove crucial in the next set of activities.

The construction of the surgical disease depends not only on both patient and surgeon's skill and expertise (the ability to describe pain, knowing how to control one's body, knowing what to look for in a patient's body, etc.) but also on the extent to which that disease can be considered to be not constructed,

and to be constraining both patient and surgeon in a similar way. As the symptoms are described and re-described, tested and experienced these elements become components of the collective. In this respect, the disease can be considered a mediation between patient and surgeon, to be added to the link between the patient's story and other cases. Such activity, which surgeons often call «finding the anatomical evidence», can pull the collective inside surgery or push it outside, can determine whether or not a surgical collective is constructed.

It is by taking the disease as something that does not depend on their interaction that surgeon and patient are brought to act upon it. This is because, by constructing its «externality» both surgeon and patient or relative can, as subjects, judge its worth. In negotiating what kind of scenario is best, participants have rejected the possibility of its judgement being influenced by the disease. By configuring diseases as external constraints on their interaction, surgeon and patient are able to take on those constraints as conditions for the exercise of judgement. Their negotiation of the outcome of the consultation are organised by the way in which they understand their decisions as «free» from the determinations of the disease (pain, disability, etc) if albeit «using» the resources made available through their activities.

The thorough organization of the patient's file enables the patient to expect the attention of a surgeon, and allows the surgeon to assume an inquiring position. This stance can sustain the actions leading to a depiction of the material and emotional environment of the patient, which, in turn, creates the conditions for including the surgeon in the collective. As a properly collaborative endeavour, surgeon and patient find ways of externalising their obligations in the form of a «surgical disease». Once again, this «external force» is the basis for their exercise of judgement over the collective.

In the same act as the collectives are configured by each set of activities the conditions for its further reconfiguration within surgery are also constructed. The process of making these links available corresponds to a repetitive, concatenated technique of self-affection performed by the collective upon itself. Those multiple constraints over the collective, in their cumulative effect, create a «surgical trajectory». In the consultation room, a «surgical trajectory» can be seen as an accomplishment of sequences of constraints and the exercise of the possibilities that they open. In this setting, it is this form of sequentiality that prevails over the obligation to go through the sets of activity

one after another. In constituting the collective as «surgical», participants also perform its surgical trajectory.

Mrs Rebelo's case can help us in further understanding this idea. In her case, the «surgical» constraints failed to affect the participants on a variety of occasions. They failed, despite the fact the patient and surgeon tried a variety of forms of interaction, because each link that they were able to establish fell short of «moving» them to and sustaining their activity of building the next association. That movement can be seen as the realisation of the force of the previous link. The strength of the relation between radiological images and descriptions of leg pain can be reinforced either by an account of the material, social and emotional environment of the patient or by the performance of reflex tests. Each of these possibilities relies on the difference between forms of interaction: doing reflex tests, talking «life», checking identities, etc.

It is not that the collective «decides» not to have surgery. It is, instead, that the collective cannot constitute itself in a way capable of making surgical forms of judgements emerge. It is impossible to decide if Mrs. Rebelo's collective «needs» surgery because it did not, in any way, become surgical in the interaction in the consultation room. It did not enact the materials that enable this form of judgement. This case, thus, exemplifies negatively the fact that the decision to have surgery can only be taken in a collective which already embodies, through a concatenated construction of involvement, the criteria of surgical judgement The failure to set up a surgical collective is also the failure to be determined by a bureaucratic file, a description of life, a disease and its narrative, to be affected by them and the activities that their afford.

In this paper, I have argued that the inclusion or exclusion of patients from surgical treatment derives partially from different interactive pathways in the consultation rooms. I suggested that the involvement displayed by participants in consultation rooms is an effect of the way in which participants delineate the constituents of their material environment. The process of mutual adjustment of materials between each other and of participants to their environment is organised by a dynamic alternation between the construction of a «dispositif» and the use of its intersubjective possibilities.

REFERENCES

Callon, M. and Law, J. (1995). Agency and The Hybrid Collective. *South Atlantic Quarterly*, *94*, 481-507.

— (1997). L'Irruption des Non-Humains dans Les Sciences Sociales: Quelques Leçons Tirées de La Sociologie des Sciences et Techniques. In B. Reynaud (ed.), *Les Limites de La Rationalité – Les Figures du Collectif* (Vol. 2). (pp. 99-118). Paris: La Découverte.

Callon, M. and Rabeharisoa, V. (1998). Reconfiguring Trajectories: Agencies, Bodies and Political Articulations: The Case of Muscular Distrophies. *Theorising Bodies in Medical Practice Workshop*, Centre de Sociologie de L'Innovation, École des Mines de Paris, September.

— (1999). De La Sociologie Appliquée à L'Opération Chirurgicale: Ou Comment Faire Disparaître La Personne du Patient. *Sociologie du Travail*, *41*, 1-20.

Goffman, E. (1961). *Encounters: Two Essays on the Sociology of Interaction*. New York: Bobbs-Merrill.

— (1963). *Behavior in Public Places*. New York: Free Press.

— (1974). *Frame Analysis*. Boston: Northeastern University Press.

Gomart, E. and Hennion, A. (1999). A Sociology of Attachment: Music Amateurs, Drug Users. In J. Law and J. Hassard (eds), *Actor-network Theory and After*. (pp. 220-247). Oxford: Blackwell.

Goodwin, C. (2000). Action and Embodiment within Situated Human Interaction. *Journal of Pragmatics*, *32*, 1489-1522.

Have, P. T. (1995). Medical Ethnomethodology: An Overview. *Human Studies*, *18*, 245-261.

Heath, C. (1986). *Body Movement and Speech in Medical Interaction*. Cambridge: Cambridge University Press.

— (1992). The Delivery and Reception of Diagnosis in General Practice Consultation. In P. Drew and J. Heritage (eds), *Talk at Work*. (pp. 235-267). Cambridge: Cambridge University Press.

Latour, B. (1996). On Interobjectivity. *Mind, Culture and Activity*, *3*, 228-245.

— (1999). *Pandora's Hope*. Cambridge MA: Harvard University Press.

Pilnick, A. and Hindmarch, J. (1999). «When you wake up it will be all over»: Communication in the Anaesthetic Room. *Symbolic Interaction*, *22*, 345-360.

Sharrock, W. (1999). The Omnipotence of the Actor: Erving Goffman on the «definition of the situation». In G. Smith (ed.), *Goffman and Social Organization*. (pp. 119-137). London and New York: Routlegde.

Winance, M. (2000). De l'adjustement entre les prothèses et les personnes: interactions et transformations mutuelles. *Handicap*, *85*, 11-26.