



Structuring times and activities in the oncology visit

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ARTICLE INFO

Keywords:

Italy
Temporality
Doctor-patient interaction
Oncology
Textual artifacts
Metapragmatic utterances
Ethnomethodology
Conversation analysis

ABSTRACT

In this paper we examine how doctor and patient coordinate actions in interaction towards the smooth accomplishment of the medical visit. Such coordination entails primarily the management of time and praxis, i.e. the apportionment of time to the tasks to be completed during the visit; and it is not an easy enterprise, for a number of reasons: 1) the tasks to be carried out during the visit are not familiar in equal measure to doctor and patient; 2) the extent of attention to be devoted to each task cannot be fully determined in advance but requires ongoing judgment and calibration; 3) generally, the timeframe of the visit is relatively limited. Our ethnographic and conversation analytic study of oncological visits shows that doctor and patient rely on a range of semiotic resources to achieve mutual understanding and coordinated actions. In particular, our analysis has identified *textual artifacts* and *metapragmatic utterances* as key semiotic components in the coordination and negotiation of the temporal trajectories and courses of actions that constitute and traverse the oncology visit.

1. Introduction

Social interaction seems such a matter of course that nothing needs to be said about it. And yet the work of ethnomethodologists, over the past 50 years, has revealed how the meaningful orderliness of social activities is an intricate stipulation that is interactionally accomplished by social actors in the very unfolding of those activities (Garfinkel, 1967, 1988; Garfinkel and Sacks, 1970; Heritage and Watson, 1980; Schegloff, 1968). In addition to ordinary social interaction, ethnomethodologists have also examined a wide range of professional practices and occupational settings—e.g. classroom, courtroom, police department—discerning the often implicit and imperceptible mechanisms that mediate coordinated courses of action and the pursuit of specialized, context specific tasks.

Drawing on ethnomethodological sensibility, in this paper we examine how doctor and patient coordinate actions in interaction towards the smooth accomplishment of the medical visit. Such coordination entails primarily the management of time and praxis, i.e. the apportionment of time to the tasks to be completed during the visit. We are thus interested in examining how temporal order arises within and in turn shapes the medical visit as social and institutional event.

The practice of medicine is deeply entangled with time and temporality. Schedules and timelines are central to the organization of medical institutions, such as the hospital (Zerubavel, 1979). Temporal trajectories delineate the course of illnesses as well as the experiences of

patients, doctors and other health personnel; and these trajectories are intricately interwoven.

Borrowing theoretical insights from the science and technology studies, Jespersen and Jensen (2012) invite to consider that every medical encounter is “a composition of multiple times” (p. 336). Their analysis of General Practice consultations shows that the 15 min of the doctor-patient encounter is not simply a self-contained event but therein different points in time, past and future, become relevant, and multiple temporal trajectories converge and depart. In Jespersen and Jensen's own words:

“one could say that the consultation folds times and make contacts between points that were previously distant (Serres and Latour, 1995). The consultation constructs a new form of contemporariness [...] a lot happens—and [...] many ‘times’ emerge—in the course of the 15 allotted minutes. The 15 minute is a circumscribed unit, but this circumscription seems to stimulate rather than prevent the traffic of times in many directions” (Jespersen and Jensen, 2012, p. 343)

Thus, the management of times in the medical visit is not simply a matter of alignment with a predefined and externally imposed schedule but rather the process of folding different temporalities (Serres and Latour, 1995) and organizing different courses of actions. As such, the temporal structuring of the visit emerges as a practical accomplishment of participants.

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In this paper we aim to analyze with unprecedented detail the ways doctor and patient produce and reproduce the temporal structures that orient and coordinate their ongoing activities. Our data corpus is comprised of oncological consultations, specifically the first meeting between oncologist and patient. Our prior research (Fatigante et al., 2016; Zucchermaglio et al., 2016) has shown how the first oncological visit is a highly complex event, in which a number of tasks are to be carried out, e.g. the anamnesis and the cancer diagnostic assessment. These activities are only in part scripted and predictable in that the completion of each task hinges on information that the doctor only acquires from the patient in the course of the visit. Moreover, these tasks and the overall organization of the visit are generally unfamiliar to the patient. Therefore, the doctor has the practical problem of moving the visit through its constitutive activities in a timely manner. The patient has the practical problem of understanding what the oncologist is doing and what is expected of him/her—what to say and when. By examining the moment-by-moment unfolding of medical consultations, our analysis discerns the material and discursive resources that participants mobilize for structuring time and praxis in a coordinated fashion.

2. Times and temporalities in medical practice

Ethnographic, interview and survey studies of medical practices have revealed how time is a key dimension of both the organizational makeup of medical institutions and the individual's experience of medical practice. Applying Simmel's methodological principles of formal sociology to ethnographic observations, Zerubavel's monograph *Patterns of Time in Hospital Life* (1979) examines how the organizational structure of a large university hospital on the US East Coast is an enactment of *sociotemporal order*. Multiple temporal patterns are interwoven in the hospital sociotemporal matrix, e.g. patients' daily schedules, nurses' coverage shifts, doctors' visits and surgical procedures schedules. Zerubavel shows the complexity of the hospital sociotemporal matrix by highlighting the distinctive and contrasting ways in which professional responsibilities of physicians and nurses are temporally structured, with the former operating with a fairly flexible schedule, typically marked by the actual completion of their tasks, and the latter more rigidly adhering to a work schedule dictated by the clock. In addition to the difficulty of coordinating these different temporal logics, Zerubavel contends that these distinct relationships with time are indexical of differences in ethical codes. As such, socio-temporal order is also moral order (Zerubavel, 1979 pp. 113–123).

On the basis of in-depth semi-structured interviews with 50 doctors who have become patients, Klitzman (2007) also reveals differences and tensions in perceptions of time in medical care. The perspective of Klitzman's subjects is particularly useful in that the interviewees had experienced both sides in the doctor-patient relationship. These subjects reported the experience of three types of time—*patient-time*, *doctor-time*, and *institutional-time*—and conflictual relations among them. For instance, as doctors they experienced primarily the pressure of institutional expectations (e.g. expected number of visits, daily), while as patients they experienced to have limited time with doctors. In light of his findings, Klitzman suggests that the effects of conflicting notions of time on patient experiences and the quality of doctor-patient interaction cannot be underestimated. He concludes by calling for further research on “how physicians and patients view and manage the time constraints and pressures that each may experience within the current health care system” (Klitzman, 2007, p. 153). This is what our study aims in part to illuminate.

Several studies focused on patient care have shown how patients' experience of time has a bearing on overall patient satisfaction (e.g. Howie et al., 1991; Like and Zyzanski, 1987; Ridsdale et al., 1989). Such an experience, however, does not seem to be strictly related to the actual length of the medical visit but rather to the quality of doctor-patient interaction (Lussier and Richard, 2007). More specifically, the

positive correlation between perception of time and satisfaction in patient experience is mediated by factors such as patient participation and initiative during the visit (Dugdale et al., 1999; Kaplan et al., 1989, 1996; Ogden et al., 2004).

While not thematically centered on time and temporalities, conversation and discourse analytic work on doctor-patient interaction has examined phenomena predicated on temporal unfolding, offering important insights on the relationship between time and praxis. Research studies in primary-care have discerned the visit's phase structure and the regular sequential order of the phases (Byrne and Long, 1976; Heritage and Maynard, 2006; Ten Have, 2006). Such orderliness is not simply the result of the doctor orchestrating the medical encounter: focusing on the transition from the activity of history taking to that of physical examination, Robinson and Stivers (2001) have detailed the interactional and multimodal coordination that allows participants to shift from one activity to the other. Other conversation analytic studies have shown that patients insert their own initiatives, such as personal concerns or additional queries, in ways that we can interpret as indicating a sensibility toward the temporal structuring of the visit (Gill and Maynard, 2006; Gill et al., 2001; Robinson, 2001; Stivers and Heritage, 2001). For instance, an interesting paper on patient initiated presentations of additional concerns (Nielsen, 2012) has revealed that those presentations do not occur randomly throughout the visit but rather they are brought up at a specific moment, i.e. right after the doctor has produced a pre-closing turn. This sequential location reveals the patient's understanding that the visit time is running out. At the same time the patient initiative produces a deferral of the closure of the consultation, in effect an efficacious modification of the temporal course projected by the doctor.

Time issues are perhaps more ubiquitous in oncology than in any other medical domain. A cancer diagnosis is overwhelmingly experienced as a traumatic event that abruptly reconfigures several aspects of everyday life and alters the perception of and relationship with time. The future becomes more uncertain and the present is often infused with an expanded sense of meaningfulness (Alby et al., 2017; Good et al., 1994; Maynard, 2003; Rasmussen and Elverdam, 2007). Drawing on interview data from two studies centered on the cancer patient perspective, Thorne et al. (2009) have examined patients' relationship with time within the context of communication with clinicians. They found that oncologists' time-related attitudes, as they transpired in the clinical encounters, had a significant impact on the patient's cancer experience. Besides recognizing how clinicians' communication of time pressure can add to the patient apprehension, Thorne et al. discuss three strategies that in their data are related to a more satisfactory experience of oncological care: (a) *creating a sensitivity to time* (pp. 502–3) (b) *buffering time challenges* (pp. 503–4) and (c) *manufacturing a sense of time* (pp. 504–5). At a most basic level, oncologists' awareness of cancer patients' heightened sensitivity towards time resulted in acknowledging “the preciousness of time” which patients experienced as “a strong symbolic message of respect” (Thorne et al., 2009, p. 503). The clinician capacity to mitigate and manipulate the impact of time pressures, particularly but not solely within the consultation encounter, was also experienced as highly beneficial to patients. Especially effective strategies were the enactment of a sense of presence and the encouragement of patient queries during the visit.

Research on patient temporalities thus shows the tight relationship between experience of time and communication and praxis during the visit. Our study contributes to this research by providing a fine-grained conversation analytic examination of how the temporal structures that organize the visit come into being in interaction. Our focus is not only on the doctor or only on the patient but rather on all participants co-present to the medical encounter. Indeed our ethnomethodological sensibility compels us to consider time as a joint accomplishment, *fabricated* ongoingly by participants in interaction (Latour, 2005).

3. Methodology

3.1. Setting

Our data collection was carried out in the oncology department of two Italian hospitals—a medium-size public hospital and the teaching hospital of the largest Italian university. The study received approval from both the Hospital Ethical Committees.

The staff of the medium-size hospital's oncology department comprises a senior oncologist and department head, three more junior oncologists and six nurses. The total amount of patients that refer to the oncology department is about three thousand per year (of whom, 440 are new patients). The senior oncologist (more than 35 years of experience) carries out approximately 30 visits every day including follow-ups, visits before chemotherapy treatment, consultations, and all the visits with new patients.

Two senior oncologists and four residents work in the oncology department of the teaching hospital. The total amount of new patients that refer to the department is about four hundred per year. The senior oncologist makes approximately 8 visits with new patients per day, while also involved in research, teaching, and supervision of residents and students.

Ethnographic knowledge of both hospitals, obtained through observations and interviews, allowed us 1) to outline the daily temporal organization of the departments; 2) to chart the different types of visit carried out in the departments and their institutional aims; 3) to understand the various medical indices and records (including, all kinds of exams and test results) and the different treatment options. This knowledge also informed the decision to center the videorecording component of the data collection on “first visits.”

Ethnographically speaking, *first visit* is an emic category, i.e. a way of characterizing an entity or phenomenon from the participants' perspective. *First visit* is the label oncologists and medical personnel of both hospitals use to refer to the first official encounter between a patient and an oncologist in the oncology department. Incoming patients to the oncological ward have already received a cancer diagnosis (delivered by a range of other specialists, e.g. surgeon, radiologist, gynecologist) and they often have already undergone a surgical removal of the tumor. The aim of the visit with the oncologist is to assess the severity of the tumor and to delineate a treatment (such as chemotherapy or hormone therapy), aimed at attenuating the risk of recurrence. In visits of this kind, the oncologist and the patient need to make decisions on cancer care, which are key for the patient's longer term health and her medical visit trajectory. Moreover, as first time encounters between patient and oncologist, these visits are complex events in which several different courses of action and temporalities need to be organized and practically accomplished by the participants.

Prior work on this data corpus has documented the structural organization of first visits (Fatigante et al., 2016). The first visit comprises six phases: (1) opening (greetings and small talk), (2) anamnesis (personal data, medical history, current health status), (3) cancer's diagnostic assessment (staging), (4) treatment recommendations, (5) outline of future actions (e.g., next appointments, exams), (6) closing (greetings). Packaging all these activities, in proper proportion and order, is a practical challenge that the oncologist has to face anew, each and every first visit.

In the medium-size hospital, the first visit has an average duration of 23 min. In the teaching hospital, the first visit is divided in two parts. The first part is led by the resident and devoted to constructing the patient anamnesis and completing the medical record (average length is 38 min). The second part—led by a senior oncologist, with the resident still present—focuses on diagnostic and therapeutic decisions and is 21-min long, on average.

3.2. Data corpus

Our dataset comprises 56 video-recorded oncology visits, 31 collected in the medium-size hospital and 25 in the teaching hospital. As previously mentioned, these are all *first visits*, that is, the first time the patient meets with the oncologist to discuss the diagnosis and therapeutic prospects after surgical procedure.

Most patients in these visits are women (80%) and have breast cancer (77%). Their average age is 55 years. The patients are usually (66%) accompanied to the visit by a family member or close friend (Alby et al., 2017). Written informed consents were obtained from all participants, i.e. the doctor, the nurse, the patient, individuals who accompanied her (e.g. a family members or a friend), and any other hospital personnel who entered the consultation room during the visit. Names and other references, which might lead to the participant's identification of personal data, were rendered anonymous.

3.3. Analytic procedures

In our analytic procedure, the visit videorecordings were first fully transcribed according to conversation analytic conventions (Appendix). Next, we focused our attention on the transitions between phases, as special loci for studying how participants orient toward and bring into being the temporal structuring of the visit. Therein, we examined the practices deployed for managing the progression of the visit and accomplishing coordinated moves of phase openings and closings. Transitional sequences were examined case-by-case, by two of us independently and then discussed collectively by all three authors.

4. Results

Our analysis has discerned two main semiotic resources that mediate participants' enactment of and intersubjective alignment with the oncology visit's temporal structure: 1) the engagement of textual artifacts, through a wide range of moves, including acts of reading and writing (Sterponi et al., 2017); and 2) the use of metapragmatic utterances. Drawing from Caffi (2006), we use ‘metapragmatic’ to refer to utterances that deal with “the know-how regarding the control and planning of, as well as feedback on, the ongoing interaction” (Caffi, 2006, p. 82). As Caffi points out, “the metapragmatic level is not just one of the metalinguistic levels” in that “the knowledge it refers to concerns not ‘the ability to say’ but ‘the ability to do’ (and the ability to say what one does)” (Caffi, 2006, p. 82). In other words, metapragmatic utterances are phrases like “let's reason together”, “outline the course of events that bring you here”, “I am going to explain this to you”, etc., which speak of what the participants are doing or project to do with words. Metapragmatic utterances could also be considered as a subclass of what Garfinkel and Sacks (1970) referred to as *formulations*, i.e. metacommunicative, self-reflexive descriptions that participants in conversational exchanges deploy to display and secure that their talk is intelligible and accountable. In Garfinkel and Sacks' own words:

“A member may treat some part of the conversation as an occasion to describe that conversation, to explain it, or characterize it, or explicate, or translate, or summarize, or furnish the gist of it, or take note of its accordance with rules, or remark on its departure from rules. That is to say, a member may use some part of the conversation as an occasion to formulate the conversation” (Garfinkel and Sacks, 1970, p. 350).

The five extracts that follow were chosen to illustrate our findings. These examples are representative of the practices in the data corpus and were selected as particularly clear illustrations of how literacy and metapragmatics weave and interweave in the temporal structuring of the oncology visit.

4.1. How to get started: doctor's and patient's negotiation over the opening of the visit

As conversation analyst Emanuel Schegloff (1968) has shown, “openings” of encounters are complex processes, requiring the coordinated entry of participants into the exchange, thus an interactional accomplishment in and of themselves (Schegloff, 1986). Through summon-answer and/or a greeting exchange, interlocutors display to each other their orientation towards and availability for engaging in the projected activity to follow.

In the oncological first visits, the transition to the official beginning of the visit is a delicate enterprise: the hierarchical order encoded in the institutional context of the oncology office positions the doctor as the orchestrator of the exchange; at the same time, the patient enters the oncology office with the expectation of being primary teller, at least at the initial stage of the visit, when the oncological problem needs to be presented.

The first example illustrates how the fine coordination of doctor's and patient's actions is achieved tacitly while requiring negotiation of timing, actions and roles. In fact, our analysis shall unveil subtle tension between patient and doctor over the demarcation of the beginning of the visit proper. In this sequence, the role of textual artifacts in mediating the participants' displays and alignments is especially salient.

Invited by the oncologist to enter the room (lines not included in the transcript here below), (male) patient and wife sit down in front of the doctor, while the oncologist keeps his focus on the computer screen. After approximately one minute, the doctor turns his gaze and torso to the patient and wife, claps his hands and greets them (Fig. 1).

Despite the gathering with the doctor could be considered to have started when the patient and his wife are admitted into the oncologist office, it is clear from the video that while the oncologist focuses on the computer screen, patient and wife are *doing waiting* for an official opening of the encounter: the patient holds tightly a red folder on his lap, with his arms crossed, and his gaze downward, somewhat blank. His wife, on the contrary, looks at the computer screen, monitoring the doctor activity. Both their posture and silence signal the expectation that it is the doctor who is responsible and entitled to initiating a change in footing and ratifying their participation into the exchange as interlocutors (Goffman, 1979).

Indeed, as soon as the oncologist turns to and greets patient and wife (lines 2, 4 and 5), the patient aligns to the footing shift by lifting his head and smiling openly to the doctor (line 3), before uttering the second pair part of the greeting exchange (line 6). At this point, the patient also orients to the material artifact (i.e. the red folder) that he is holding on his lap as something relevant to the course of action now underway: he opens the folder and leafs through the papers therein contained (Fig. 1a, b, c; from later in the videorecording, it will transpire the papers to be medical reports, i.e. the histological exam and body scans). Concurrently, the doctor turns his torso away from the patient toward the cabinet, from where he takes a blank medical record form. Once he has it on his desk and begins filling it out with the patient name, uttering it aloud (line 12), the patient has the red folder back closed on his lap (Fig. 1d).

It thus emerges a mismatch between the course of action anticipated by the patient and that carried out by the doctor. The patient displayed an orientation towards the documents he has brought to the visit to become the immediate focus of the doctor's attention. The doctor's action, however, signals that filling out the medical record form is the appropriate next activity to carry out. It is a subtle tension in that it is entirely negotiated tacitly and ultimately it emerges as a matter of temporal order of activities: the documents that the patient has in the red folder will indeed be needed later on in the visit, during the cancer's diagnostic assessment.

In summary, example 1 shows that the temporal structuring of activities during the visit is ongoingly produced and negotiated by doctor and patient. Such a construction is a joint accomplishment, requiring

fine-tuned coordination of actions between participants. It is not however a symmetrical process in that the course of action launched by the oncologist has the primacy over the patient initiative. It is not a purely *interpersonal* exchange either in that we can clearly observe in this sequence the *shaping role of artifacts* (Caronia and Mortari, 2015), specifically the agentic capacity of documents (Cooren, 2004), which mediate the coordination of action between doctor and patient. The medical record form, towards which the oncologist orients as dominant axis of involvement (Goffman, 1963) in this phase of the visit, provides a template for the joint activity, organizing both participation framework and practice (Berg, 1996). The sequence will unfold in a series of questions and answers, with the doctor inquiring and the patient providing information. The written artifact also contributes to the temporal partitioning of the visit, indicating when the anamnesis phase is completed.

Example 2 also shows the interactional work that is needed to doctor and patient, at the beginning of the medical encounter, to coordinate their action toward a smooth and efficient unfolding of the visit. In this extract, the time pressure on the participants is made especially salient by both material and discursive strategies, involving the handling of medical documents as well as metapragmatic formulations.

The patient and his wife have just entered the oncology room and have not yet taken their seat. The doctor, seated at his desk, immediately asks the patient to present his medical problem, before standing up to reach the cabinet and pull out a medical record form (Fig. 2).

The absence of small talk and the immediate request for the formulation of the medical problem (line 1) convey a sense that the oncologist is oriented toward a compressed structuring of the visit. It is noteworthy also to consider that this visit starts with delay with respect to its official scheduling and encroaches on the oncologist lunch break. Subtle misalignment and tension over the pace of the visit transpire quite quickly: while the doctor solicits a prompt formulation of the problem, the patient delays his reply (lines 2, 4, and 6). At the same time, the patient responds in a way that reveals his sensitivity to the time pressure: he first asks the oncologist whether the full story is preferable to him (line 7), and shortly after (line 15), he expresses his willingness to accommodate to the doctor preferred *modus operandi*.

The oncologist response can be unpacked into three components: 1) an unmitigated dispreferred reply (i.e. a rejection, “no” in line 9), uttered while he is still standing and giving the back to the patient; 2) a directive, in lines 11 and 12; and 3) a declarative formulation, line 13, which syntactically is doubly marked, with the presence of the pronominal subject placed after the verb (Italian is a pro-drop, S-V-O language). Both the directive and the declarative provide the patient with metapragmatic instructions that project, respectively, a general description and then question and answer as preferable next actions. The instructions also include temporal markers—“first of all,” in line 11, and “then,” in line 13—that indicates the preferred order for the projected actions. As such, in its composite make-up, the oncologist response comes across as authoritative and somewhat disaffiliative. The expansion that follows (lines 17, 18 and 20), which clarifies the intended course of action, seems to mitigate its disaffiliative import (Peräkylä, 1998).

In the subsequent talk, we observe both patient and doctor acting towards repairing the misalignment: the tight latching of their turns, which include collaborative completions (lines 21 and later on, lines 27–28), instantiates and is indexical of the coordination achieved by doctor and patient and their now converging orientation towards temporal efficiency. Some tension however lingers, on the side of the patient, who delays his reply (line 22) and prefaces his answer proper to the doctor request with a comment that displays an orientation toward narrating his condition, in full or abbreviated, rather than providing a concise medical definition (lines 23–25). Furthermore, instead of completing the formulation of the medical problem, the patient takes

Example 1

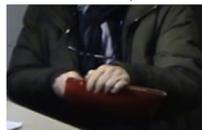
Participants: ONC (ologist), PAT (ient, 52 yrs old), WIFE

- 1 (2.5) ((PAT, who is seated in front of ONC, has a red folder on his lap. He stares downward. WIFE sits on his left, looking at the doctor's monitor))
- 2 ONC: o[cchei,
o[kay, ((turning toward the couple))
[((PAT lifts his gaze toward ONC and smiles))
- 3
- 4 (0.6) ((ONC claps hands and rapidly stretches them out toward PAT))
- 5 ONC: buongiorno.
good morning.
- 6 PAT: buongio(h)rno °a [lei°.
good m[orning to [you . ((smiling))
[PAT looks at the red folder on his lap and touches it ((see Fig. 1a and b))
- 7
- 8 WIFE: [°'giorno°
[°`morning° ((smiling))

FIGURE 1a



FIGURE 1b (detail)



- 9 (2.0) ((ONC turns right and stands up, PAT opens the folder. Fig. 1c))

FIGURE 1c



- 10 (9.0) ((ONC opens the locker and takes a new, blank medical record form. PAT turns his gaze toward ONC and closes the red folder))
- 11 ONC: .h eh ((turning toward the desk))
.h well
- 12 [yyy yyyy ((patient's last name, that sounds similar to doctor's own last name))
[((ONC puts the medical record form on the table))
- 13 solo i[o lo dovevo cura'
it's only m[e who could cure you
[((PAT nods, smiling. He has the red folder closed on his lap again. See Fig. 1d))

FIGURE 1d



- 14 PAT: heh, infatti. hhh
yeah, exactly. hhh ((laughs))

Fig. 1. Example 1.

some papers out of a folder he took to the visit and places them in front of the oncologist (line 25). We would argue that with this move the patient removes his voice, that is he partially abstains from providing the information the doctor had solicited and gives him the responsibility to extract it himself, from the documents just handed to him. The patient is both submitting to the oncologist authority but also charging him with a task that the doctor was oriented to accomplish collaboratively with him.

In summary, example 2 has shown how the temporal structuring of the visit is continuously open to negotiation, traversed by tension among participants, managed and revised by means of assemblage of different semiotic resources, including language, gaze, posture, silence, and documents. This example has also revealed the relationship between temporality and kinds of conversational sequences (e.g. question and answer, narrative, definition) and between kinds of conversational sequences and participation framework. Time pressure informs and

manifests through the preference for a concise formulation of the problem and a Q&A follow-up. This speech activity positions the patient as informant, i.e. mere respondent to the doctor queries, a role that is different from, arguably more constraining than that of narrator, which the patient had projected for himself in suggesting that he told his full story.

4.2. How to regulate the pace of the visit and the shift between phases

Once the visit is underway, the pacing of activities and transitioning between phases become central to oncologist's verbal and non-verbal actions. The next two examples illustrate how the doctor maneuvers to transition from one course of action to the relevant next, as well as to regulate the pace of activities, at times slowing them down, at times speeding them up.

In example 3 we find participants farther along in the encounter,

Example 2

Participants: ONC (ologist), PAT (ient, 61 yrs old), COM (panion), RES (earcher) and a female oncologist are also present in the room.

```

1 ONC      di che si tratta.
           what is it about.
2 (1.5)    ((ONC is seated, looking to COM e PAT in front of him))
3 PAT      allora,
           so,
4 (1.0)    ((COM seats))
5 ONC      hh ((clearing his throat, he stands up))
6 (2.0)    ((ONC moves to the locker at his right and opens it))
7 PAT      le faccio la storia: (.) per esteso?
           shall I tell you the story:, (.) in full? ((putting his jacket on the seatback of
           the chair, standing))
8 (.)
9 ONC      no.
           no. ((ONC faces the locker with his back to the patient and companion))
10 (0.8)
11 ONC     prima di tutto, (.)
           first of all, (.) ((taking a blank medical record from the locker))
12         vagamente, dica:, di che malattia si tratta,
           vaguely, te:ll, what's the illness,
13         poi preferisco farle io, le do[mande.
           then I'd rather ask you qu[estions.
14         [((ONC puts the medical record on the table))
15 PAT     asso[lutamente sì. allora è un:
           abso[lutely yes. so it is:
16         [((PAT sits down, he places a plastic bag on his lap))
17 ONC     intanto per inquadrarla,
           just to begin framing it,
18         così faccio le do[mande, (.)
           so that I pose qu[estions, (.)
19         [((PAT nods, and takes out of the bag a brown envelope))
20 ONC     consequ[enziali.
           con[tingent.
21 PAT     [mirate.
           [targeted.
22 (1.2)    ((ONC opens and browses his agenda, PAT opens the envelope))
23 PAT     l'ho sen[tito , e l'ho detto.
           I liste[ned to it, and I told it.
24         [((PAT takes out a document from the envelope))
25         decine di volte, ma- (.) hmf:
           dozens of times, but- (.) hmf: ((puts document on the desk in front of the doctor))
26 (0.6)    ((ONC looks at the document))
27 ONC     quindi, è u:n, (.) problema, del,
           so, it's a:, (.) problem, of the, ((looking at the document))
28 PAT     dell' in[testino.
           of the in[testine. ((slightly shakes his head))
29 ONC     [colon. ((looking at the document))
30 (1.0)
31 PAT     °°colon°° ((while putting the envelope in the plastic bag))

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Fig. 2. Example 2.

Example 3

Participants: ONC (ologist), PAT (ient, 69 yrs old), DAU (daughter)

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((doctor sits in front of PAT and DAU, he ends phone call))
1 ONC     allo:(h)ra.
           s[o:(h) .
2         [((ONC gazes on the phone and switches it off))
3 (10.0)  ((ONC removes his glasses, takes the pen and starts writing on the medical record; PAT and DAU
           monitor doctor's activity))
4 ONC     .h ↑>al[lora<= m-
           .h ↑>s[o<= m-
5         [((ONC puts down the pen, looking down at the record on his desk))
6         praticamente,
           practically,
7 (.)    ((DAU lifts her gaze to ONC))
8         f[acciamo una:: (.) u- un ragionamento.
           l[et's:: (.) reason together.
9         [((ONC raises his gaze toward DAU, and then PAT))
(... ) ((ONC starts explaining))

```

Fig. 3. Example 3.

when, as per the standard phase structure of the visit, the diagnostic assessment is upcoming, in turn preliminary to the formulation of a treatment recommendation (Fatigante et al., 2016). The oncologist had been called outside the visit room for a brief consultation with a colleague. When he reenters the room, he is on the phone, which takes his attention for approximately 3 min prior to the beginning of the episode transcribed (Fig. 3).

Once the call is over, the oncologist utters the topic-initiating marker “allora”, which shares with its English equivalent “so” the meaning of “emerging from incipency” (Bolden, 2009, p. 988): it characterizes “the upcoming action as having been ‘on the speaker’s mind’ or ‘on agenda’ for some time” (Bolden, 2009, p. 976). As a matter of fact, while uttering “so” the doctor does not look at the patient, orients his gaze to the medical record, and starts writing therein information the physical exam yielded; then, he stops, places the pen on the table and addresses the patient and the daughter, recycling the topic-initiating marker (lines 4 and 5). This second occurrence, uttered with a high pitch onset, is latched to the continuation of the turn, which explicitly recruits his interlocutors as legitimate addressee of his talk (though, the oncologist only gazes at them later, in line 9). In both cases the verbal marker, in conjunction with gaze and non-verbal action, orients the patient and companion to align with different footings—first as bystanders, to the doctor writing activity, and then as co-participants to the reasoning activity.

Thus, engagement with textual artifacts, here primarily through acts of reading and writing, carried out *on display*, so to speak, observable to the patient, are implicated in regulating the completion of different phases of the visit and the transition between phases. The orientation to documents and documenting (via writing) is frequently complemented with metapragmatic phrases—as “let’s reason together” (line 8) in example 3—which offer to the co-participants further indication for understanding what is going on and aligning and contributing to the doctor’s course of action.

In the next example, similarly, we observe the deployment of writing in conjunction with metapragmatic comments. In this case, the doctor seems oriented toward expediting the pace of the visit, more specifically the completion of the anamnesis phase. As discussed in relation to example 2, regulating the temporal span and pace of the anamnesis is especially challenging since, more than in other phases of the visit, the patient is the primary teller. Moreover, during the anamnesis, the oncologist cannot predict in advance if follow-up questions will be necessary in light of the information the patient will give him.

In example 4, the anamnesis phase has been unfolding for several minutes, with the patient holding the floor steadily, articulating a lengthy and intricate list of events, including hospitalizations, surgeries and post-surgical complications. The patient is forced to stop when the oncologist is called outside by the nurse for a concurrent emergency. The transcript here below starts when the doctor gets back into the room (Fig. 4).

Unexpected time away from the patient inevitably forces a readjustment of the pace of the visit. Indeed, the oncologist seems to reenter the room with increased pressure: he apologizes to the patient as soon as he is back (line 3) and even before regaining his desk he invites returning to the medical history taking (line 5). It is worth noticing that he frames the activity to be resumed as a collective pursuit, using the first person plural pronoun *we*. And it is the patient’s husband, as a matter of fact, who provides a first reply (line 6), followed by the patient (line 7) and oncologist (lines 8 and 10).

At this point the patient takes the floor again (lines 13 and 14), her turn affirming capacity and intention to properly report about her illness experience while also displaying sensitivity to the time pressure: She uses a story preface (line 13), thus announcing a turn longer than usual (Sacks, 1974) but, by adding the temporal reference “a moment” (line 14) she qualifies her story-telling as brief. Her narrative, however, is lengthy. While the patient deploys several devices to keep the recipient interested (e.g. bending over the desk, suspended intonation and

pauses, which invite mutual gaze and back-channeling), the oncologist initially displays minimal engagement with the telling, looking more at the medical documents on the desk than at the patient. He also taps with his pen, in line 19 and 21, while looking at the patient, an action that might be interpreted as a sign of impatience.

In line 25, the oncologist proffers a collaborative completion to the patient narrative, which she confirms immediately as correct (line 26). This oncologist’s intervention seems oriented to accelerate the report. In addition, the fact that the doctor can anticipate what the patient was about to say could be taken as conveying that he knows where the story is going and does not need further unpacking. Indeed, after the collaborative completion, the doctor utters an assessment (a quite ironic one: “cool”, line 25), which in everyday storytelling is relevant at story completion (Jefferson, 1978).

The patient, however, continues on with her narrative and there is no prosodic or syntactic element that indicates it is approaching its end. The oncologist then begins to write on the medical record and in a brief pause within the patient recounting he intervenes with a declarative utterance that states what he is in the course of doing, i.e. writing down “with various complications” (line 33). This way the oncologist, on the one hand treats the patient’s narrative as worthy of inscription; on the other hand, however, by synthetizing it onto the general formula “various complications” he makes any other detailed elaboration unnecessary. As such, the oncologist’s utterance is oriented towards the closing of the narrative, pushing for it. Clearly, here again, the conversion of the patient’s telling into medical terminology to inscribe into the official record marks the prominence of the doctor’s biomedical register over the patient’s narrative style. At the same time, viewed in the perspective of the construction of an intersubjective agreement with the patient, the inscription also operates as a reparative strategy in that it allows the doctor to solve a misalignment with the patient, regarding what relevant information to report in the history taking, without the need to topicalize or explicitly sanction the patient’s initiative.

4.3. How to bring the visit to a close: bridging past, present and future times and practices

We provide a final illustration and analysis of the way participants construct and align to the temporal structure of the oncology visit by considering the closing of one such visits. In fact, we shall see how the transcript reveals that the medical encounter that is about to end is situated in courses of actions and temporalities that extend beyond the visit proper and involve a number of other medical units and professionals. Therefore, in bringing the visit to its close the oncologist projects action into the future and orients the patient toward that trajectory of time and practice (Fig. 5).

Earlier in the visit, the patient has been informed that she will undergo radiotherapy and the oncologist has written down for her a list of radiology centers (artifact 4 in Fig. 5) which she could contact to schedule her treatment.

Once again, in example 5, the doctor uses the discourse marker “allora” (so) to open a new course of action, here the closing of the visit (line 1). He then delivers a series of directives to the patient (lines 1–8, 17–22). These instructions project future medical encounters, specifically with the radiotherapist and the head nurse. Each meeting is mediated by a set of documents, notably the histological exam and a cover letter for the radiotherapist, and a referral for the head nurse. It is worth noting that the doctor anticipates different courses of action to require different paces. We understand from ethnographic inquiry and other visits’ videorecordings that radiotherapy cannot be deferred to more than 3 months from the surgery. The oncologist’s cover letter is thus likely designed to emphasize the necessity to proceed in a timely manner. By contrast, the thrombophilia screening can be carried out “with no rush”.

It is of special analytic interest the fact that the oncologist uses a marked intonation in delivering the instruction and in the composing of

Example 4

Participants: ONC(ologist), PAT(ient, 62 yrs old), HUS(band)

1 ONC eccoci.
here we are. ((entering the room))

2 (1.0)

3 ONC scusi.
I'm sorry. ((walking to his seat))

4 PAT ng: si figuri. dottore.
no problem. doctor.

5 ONC dov' eravamo rimasti.
where were we.

6 HUS ai vaccini.
at vaccines.

7 PAT eh eravamo rimasti al:
eh we were left at:

8 ONC al pancreas.
at the pancreas. ((sitting down))

9 PAT si.
yes.

10 ONC a- a: ai vaccini.
a- a: at vaccines. ((removing his glasses))

11 PAT ec[co.
right.

12 ONC [vabbe' poi me lo ricordi.
[alright remind me of it later. ((looking at the medical record))

13 PAT si. = le volevo dire una cosa.
yes. = I wanted to tell you something.

14 [giu - f: finire un attimo questa storia.
[just - t: to finish a moment this story.

15 ((ONC looks downward, to the pen he has in his hands))

16 PAT e:
a:nd ((bending over the desk))

17 (0.5) ((ONC turns his gaze away from the patient, over the documents))

18 mi hanno m[esso
they placed on me

19 ((ONC starts tapping with the pen on the desk and turns to PAT))

20 tu[tta una serie di drenaggi. ovviamente,
a full series of drainages on me. obviously,

21 ((ONC continues to tap with the pen))

22 ONC (0.4) ((nods and stops to tap))

23 PAT uno s'è tolto, (.) mi è andato in circolo il liquido pancreatico,
one of them unfastened, (.) the pancreatic liquid got into the circulation,

24 ho avuto: =ho [subito
I had: =I [suffered

25 ONC [la pancreatite= (f[igo)
[pancreatitis= (c[ool)

26 PAT [esatto.
[exactly. ((nodding))

27 ho subito la: perforazione del polmone, e della: dello stomaco.
I suffered the: perforation of the lung, and of the: the stomach.

28 ONC ((lifts his eyebrows and widens his eyes))

29 PAT .h sono stata ricoverata in rianimazione,
.h I have been hospitalized in intensive care,

30 al XXXXXX, per tredici giorni
at the [XXXXX, ((name of the hospital)) for thirteen days,

31 ((ONC starts writing))

32 (1.0) ((ONC writes, looking at the record))

33 ONC allo' io scrivo con varie complic[(hh)anze.
so I write, with various complic[(hh)ations ((slightly laughing)).

34 PAT [ecco bravo.
[yes good. ((nodding))

Fig. 4. Example 4.

the cover letter (meant to introduce the patient's request for radiotherapy to the distant colleagues). Borrowing from Day-O'Connell (2013), we characterize this stylized intonation as *sung speech*: higher pitch and harmonic, combined with longer syllabic duration, "which are conventionally associated with the vocal production of singing" (Day-O'Connell, 2013, p. 454), indicate "a certain element of predictability or stereotype in the message" (Day-O'Connell, 2013, p. 454), in short the impression of routine in the projected course of action (see also Ladd, 1978). We suggest that in this fashion, the oncologist displays his professional accountability as a way to reassure the patient: as oncologist, his responsibility extends beyond the visit, with its key objectives (i.e. diagnosis and treatment recommendation), including ensuring that the patient will follow all necessary steps useful for her recovery or for minimizing the risks of recurrence. These steps are predictable and routine for the oncologist. Additionally, as Day-O'Connell (2013) suggests, when a speaker breaks into sung speech it is

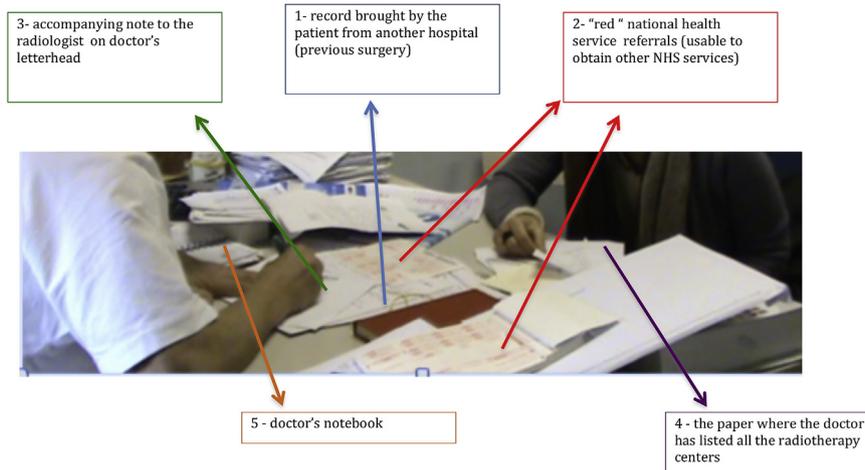
to indicate playfulness. This is in line with semantic elements of the oncologist speech: the doctor concludes his writing of the letter with a mocking expression (line 12). In parodying his own professional activity, the oncologist distances himself from his institutional role and brings into being another axis of alignment with the patient, who responds affiliatively by laughing (line 14).

As the sequence of instructions has reached its end (lines 25–26), a long pause follows (6 s, line 26) before the doctor formally opens the closing greeting exchange. Here, we observe both participants orienting to and arranging the set of documents, which hold for them a commitment to continue on with the medical activities. Particularly the patient, as the closing greeting exchange unfolds, checks whether she has collected all the documents she has to handle (line 29), likely aware that once she is out of the oncologist room it will be these documents that will guide her into other medical units and needed activities.

Overall, example 5 shows how the composing and maneuvering of

Example 5

Participants: ONC(ologist), PAT(ient, 58 yrs old)



1 ONC: allora. lei prende (.) l'esa:me is[tolo:gico che ha portato a me,
so **you take(.) the his[tological test that you brought to me,**
2 *(((ONC lifts the document and looks at PAT))*

3 PAT: m=mh *((nodding))*

4 ONC: questa impegnativa,
this referral, *((chanting tone; slides the referral toward the patient))*

5 PAT: sì
yes

6 ONC: e qu[esto biglietto di accompagnamento, (0.4)
and **this accompanying note,** *((cover letter)) (0.4)*
7 *(((ONC starts writing))*

8 a:i colle:ghi della radioterapi:a,
to my: radiotherapy colleagues *((writing, chanting tone))*
9 (1.5)

10 ONC: la signo:ra, (1.0) Yyyyyy, (1.0) XXXXXX,
madam, *((writing, chanting tone))* (1.0) **yyy,** *((PAT's last name))* (1.0) **xxx** *((first name))*
11 (2.0) necessita, (1.5) di, (.) radio terapia. ()
(2.0) needs, (1.5) radiotherapy. () *((writing))*

12 per carcinoma in situ. (1.0) grazie e cordiali salumi,
for in situ carcinoma. (1.0) thank you and best delicatessen¹,

13 (1.5) *(((ONC signs the note))*

14 PAT: mh, mh.
mh, mh. *((laughing, while she looks at the oncologist note))*

15 ONC: va bene?
alright?

16 PAT: *((nods))*

17 ONC: noi c[i vediamo a radioterapia finita.
we will me[et once the radiotherapy is completed.

18 PAT: [°okay°

¹ The bizarre closing is a pun: the word "salumi" (delicatessen) is selected for its resemblance to the Italian word "saluti" (greetings).

19 ONC: nel frattempo,
in the meantime, *(((ONC removes the note from the block note and hands it to PAT))*

20 PAT: sì?:
oka:y?

21 ONC: uno di questi giorni, (1.0) con tranquillità, (.)
one of these days, (1.0) *(((ONC starts to fill a red referral))* **with no rush,** (.)
22 va dalla caposala, co' questa scree:ning, trombophilia,
you go to the head nurse, with this trombophilia scree:ning, *(((referral))*
23 (5.0) *(((ONC writes, PAT collects and folds together the papers))*

24 ONC: occhei?
okay? *(((writing))*

25 PAT: occhei.
okay.

26 (6.0) *(((ONC stamps the referral. PAT collects the other medical documents))*

27 ONC: buone cose.
best wishes.

28 (0.5) *(((ONC hands the referral to PAT))*

29 PAT: grazie. (0.5) occhei. ho preso tutto sì?
thank you. (0.5) okay. I took everything didn't I?

30 ONC: sì.
yes.

31 (3.0) *(((ONC surveys with his gaze the desk))*

32 ONC: arrivederci
good bye *(((waving his hand to PAT))*

33 PAT: grazie =eh?
thank you uh? good bye

34 (1.5) *(((ONC and PAT shake hands))*

Fig. 5. Example 5.

written documents, combined with verbal formulations that instruct the patients on what is currently happening as well as on what is to follow, contribute not only to the structuring of temporalities within the local encounter and differentiating one activity from another in the visit, but also to the shaping of temporalities that extend past the visit into the future.

5. Discussion

In this paper we have examined how, in the oncology visit, doctor and patient produce and negotiate the temporal structures that orient and coordinate their ongoing activities. Predicated on the assumption that time and praxis are deeply entangled and mutually constitutive (Latour, 2005), our study has investigated the interactional manufacturing of courses of actions, where temporal order and practical order are simultaneously constituted.

The oncology visit is a complex encounter. A number of tasks have to be carried out during the visit, which are known in advance to the doctor but not to the patient. At the same time, it is the patient who holds information about her illness. At least until the beginning of the visit, she has primary access to her health history and the documentation pertaining her oncological condition. Due to this initial *epistemic gradient* (Heritage, 2012), the oncologist can only ongoingly—as he gains access to the needed information—ascertain the extent of attention needed for each task. These attributes of the oncology visit, i.e. asymmetrical access to information and inherent uncertainty, necessitate continuous monitoring and calibration among participants of each other's understanding as well as moment-by-moment decision making. As our examples have illustrated, the official opening of the visit and its closing, as well as the transition from one phase to the next, are not straightforward processes dictated by predefined and externally imposed signals. The temporal and praxeological structuring of the visit is (re)constituted anew from within, i.e. at each encounter between oncologist and patient.

Action upon textual artifacts and metapragmatic utterances have emerged from our analysis as key semiotic resources that mediate coordination of action of doctor and patient. Participants deploy and rely upon these resources in orienting towards, (mis)aligning with, as well as implementing different courses of actions. We provided illustrative examples of such semiotic mediation. While never mobilized in isolation, we have evidenced how documents are crucial agents in constituting the interactional and temporal order of the visit (Caronia and Cooren, 2014): we have observed the placement of the medical record form on the doctor desk to mediate the official opening of the visit (example 1); the handing back to the patient of her medical documents, along with new ones produced in the course of the visit, to mediate the closing of the encounter (example 5); acts of writing to mediate the transition between phases as well as shifts in pace of the ongoing activity (examples 3 and 4). We have also observed written artifacts to orient the patient into the future, anticipating yet unrealized courses of action, which the documents set in motion and will scaffold step by step. Thus, written documents emerge as highly complex semiotic artifacts: on the one hand, they are latourian *immutable mobiles*, permanent and transposable objects, asserting their transcontextual validity (across spatial as well as temporal contexts) and holding in themselves the authority of a profession (Latour, 1986). On the other hand, they are highly indexical objects, becoming meaningful *situatedly*, i.e. in the here-and-now of the present use, while simultaneously linked to past and/or future courses of action (Caronia and Mortari, 2015). As such, written artifacts fold in themselves multiple temporalities.

In addition, our analysis has shown that participants' orientation towards the smooth accomplishment of the visit is displayed and enacted via metapragmatic utterances—densely packaged formulations that provide information about the ongoing activity or what it is expected next in the visit, with their interactional correlates. Example 2, in particular, has illustrated the deployment of phrases (e.g. “start with

telling vaguely” and “I'd rather ask questions”) that orient participants to align to a certain course of action, i.e. Q&A, which is presented as more pertinent to the current activity than narrative (to tell “the full story”). As Example 4 has also revealed, narrative talk is harder to control for the oncologist. Encoded within these courses of action are different participation roles and epistemic statuses. The Q&A format positions the patient as knowledgeable about the matters under inquiry and the doctor as lacking such knowledge (Heritage and Raymond, 2012). At the same time the Q&A format enacts the entitlement of the doctor to ask questions as well as to determine when enough information has been provided, if follow-up questions are needed, etc. Along with distinct participation roles and epistemic statuses, the two different courses of action also entail different temporalities; notably, the narrative sequence entails extended temporal scope whereas providing a gist definition is temporally more contained, and Q&A potentially too. In Example 3 we have observed the oncologist deploy a metapragmatic utterance (“let's reflect on this”), combined with non-verbal action (removing reading glasses, putting down the pen and gazing at the patient), to mark the beginning of another activity (i.e. collective reasoning). At the same time the metapragmatic utterance provided instructions to co-participants for the proper shift in participation.

While throughout the encounter participants display an orientation and commitment towards the smooth unfolding of the visit, the temporal and praxeological structuring of the interaction is not devoid of tension. In several of our examples, albeit in different forms and intensity, we have identified moments of misalignments, resistance and attempts to alter courses of action. In example 1, we observed a mismatch between the temporal order anticipated by the patient and that projected by the oncologist. In example 2, the clash between doctor and patient was subtle and yet sharper, in that the patient's positioning as primary teller and his orientation toward the production of an extended narrative was downgraded by the doctor. The patient then adapted to the sequence organization and participation framework preferred by the oncologist but withdrew his voice, handing relevant medical documents to the doctor for him to extract from them the needed information. In example 4, the patient's extended narrative was only partially ratified and supported by the oncologist, who through affiliative moves (such as collaborative completions and ironic assessment) eventually curtailed the patient turn and brought the telling to a close.

It thus emerges a more complex picture in which not only doctor and patient work collaboratively towards the smooth unfolding of the visit. Oncologist's and patient's expectations and exigencies may collide. In episodes of tension and misalignment, maneuvering with medical documents and metapragmatic utterances have emerged as both enactments of these frictions and strategies for alleviating them. Oncologist's and patient's negotiations lay at the intersection of time and praxis and strive to attain a more favorable temporal and practical order.

6. Conclusions

With ethnomethodological sensibility, our study has documented how the temporal structures that organize the oncology visit come into being in the interaction between doctor and patient. As such, our work augments sociological research (e.g. Zerubavel, 1979, 1981) and science and technologies studies (e.g. Latour, 2005; Serres and Latour, 1995), providing a more granular analysis of the semiotic resources, verbal and material, that mediate temporal structuring in medical and other institutional contexts. In addition, we have offered more details to prior work's documentation of the unfolding and *folding* of different temporalities in the medical encounter (e.g. Jespersen and Jensen, 2012). In turn, our work could surely be expanded and deepened in at least three directions: 1) By extending our inquiry longitudinally and across medical contexts, since the oncological first visits are situated in

wider trajectories of illness experience and medical action. 2) By complementing our data corpus of oncology visits with interview data on patient's and doctor's experiences of temporal dimensions of their encounter and their relationship more broadly. 3) By carrying out a systematic inquiry into episodes of misalignments, to discern with greater accuracy the threats to intersubjectivity and cooperation that emerge in the oncology encounter.

Theoretical insights as well as practical implications can be drawn from our study. The notion of interactional fabrication of times in oncology—mediated by language and material artifacts, notably written documents—offers an alternative to perspectives that have either emphasized institutional time or subjective time. In the oncology visit, participants, with their distinctive subjective stances and orientations, are continuously drawing on the temporal structures that they reify and negotiate in the very interaction. In this sense, the institutional and subjective are deeply intertwined.

The picture of the patient that emerges from our study is one in which she strives for initiative and competence. In line with other conversation analytic studies of doctor-patient interaction, our work attests to the co-constructed nature of the orderliness and accomplishment of the medical visit (e.g. Gill and Maynard, 2006; Robinson and Heritage, 2005; Robinson and Stivers, 2001; Stivers and Heritage, 2001). Our work, however, also unearths asymmetry, ambivalence, and tension between doctor and patient over the management of courses of action and their pace and temporal extension.

Having attested to the laborious interactional work that goes into the temporal and praxeological making of the oncology visit, as well as to the occurrence of misalignment and resistance, our work corroborates prior research that has pointed to attentive and explicit communication about time and activities as key to the time management in medical encounters (e.g. Braddock and Snyder, 2005; Thorne et al., 2009). We thus conclude suggesting that a deeper commitment toward mutual intelligibility, leveraging more intentionally the semiotic affordances of documents and metapragmatic utterances, can yield a more favorable experience of time for both the patient and the oncologist.

Acknowledgments

This study was financially supported by the University of Rome, La Sapienza (2011–2013). The same institution funded a visiting professor 3-month stay (academic year 2016–2017) for Laura Sterponi to support work on the project: “Literacy practices in oncology visits.” The authors would like to express their gratitude to the anonymous reviewers and Senior Editor, Professor Timmermans, for their comments and critical guidance in the process of revising this paper.

Appendix. Transcription conventions

Notational conventions employed in the transcribed excerpts include the following

.	The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence
?	The question mark indicates rising intonation, not necessarily a question
,	The comma indicates “continuing” intonation, not necessarily a clause boundary
:::	Colons indicate stretching of the preceding sound, proportional to the number of colons
=	Equal sign indicate no break or delay between the words thereby connected
-	A hyphen after a word or a part of a word indicates a cut-off or self interruption
<u>word</u>	Underlining indicates some form of stress or emphasis on the underlined item

WORD	Upper case indicates loudness
(...)	Double parentheses enclose descriptions of conduct
(word)	When all or part of an utterance is in parentheses, this indicates uncertainty on the transcriber's part
(... ...)	Empty parentheses indicate that something is being said, but no hearing can be achieved
(1.2)	Numbers in parentheses indicate silence in tenths of a second
(.)	A dot in parentheses indicated a ‘micropause’, hearable but not readily measurable; ordinarily less than 2/10 of a second
[Separate left square brackets, one above the other on two successive lines with utterances by different speakers indicates a point of overlap onset.

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