MEDICAL INTERACTION IN KOREAN DENTAL CONSULTATIONS

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ABSTRACT OF THE DISSERTATION

Medical Interaction in Korean Dental Consultations

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This dissertation examines the endogenous organization of dental consultations in Korea. Using the methodology of conversation analysis, this dissertation explicates the particular ways in which tasks and activities are accomplished in Korean dental encounters. The dissertation advances our understanding of the specialty- and culture-specific practices of dental care in Korea as well as the generic practices of social interaction.

First, I examine the design of the dentist’s very first turn that initiates interaction with patients and the subsequent interactional trajectories. The analysis reveals that the dentist uses either a task-oriented or a non-task-oriented first turn. With a task-oriented first turn, the dentist moves directly to the business of the visit, facilitating the progression of the consultation. With a non-task-oriented first turn, the dentist invites the patient to engage in the opening activity to produce a more social/personal encounter, postponing the launch of medical activities.

Second, I show how dentists, nurses, and patients collaboratively accomplish the transition into the activity of dental examination. Transitions can be accomplished
without referring to the examination as participants closely monitor each other’s talk, bodily conduct, and object manipulation, and make relevant contributions. Dental professionals may explicitly refer to the examination when they anticipate a delay in the other parties’ cooperation. It is demonstrated that participants accomplish transitions smoothly by orienting to local contingencies as well as the routine order of the transition steps.

Third, I show how the dentist presents ‘good’ and ‘bad’ oral hygiene results to patients. Positive oral hygiene evaluations are produced straightforwardly and without delay whereas negative evaluations are not stated outright. The dentist presents images of dental plaque to patients with poor oral hygiene to avoid displaying an overt judgment about patients’ self-management while motivating them to reflect upon their self-care habits.
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# TABLE OF CONTENTS

ABSTRACT OF THE DISSERTATION ................................................................. ii  

ACKNOWLEDGEMENTS ................................................................................... iv  

TABLE OF CONTENTS ...................................................................................... vi  

LIST OF FIGURES ............................................................................................ ix  

Chapter 1: Introduction .................................................................................... 1  
  Dental Visits in Korea: Contextual and Cultural Particularities .................... 1  
  Overview of the Dissertation ........................................................................... 4  

Chapter 2: Literature Review ............................................................................ 6  
  Patient-Centeredness, Therapeutic Alliance, and Provider-Patient Communication..... 6  
  Conversation Analytic Research on Medical Encounters .................................... 9  
  Research on Dentist-Patient Communication .................................................. 13  
  Research on Doctor-Patient Communication in Korea ....................................... 16  

Chapter 3: Data and Methodology ................................................................... 19  
  Data and Setting ............................................................................................. 19  
  Methodology .................................................................................................. 21  

Chapter 4: The Dentist’s First Turn-at-Talk in Korean Dental Visits ................. 25  
  Introduction .................................................................................................... 25  
  Background .................................................................................................... 26  
    Conversational Openings ............................................................................. 26  
    Openings of Medical Consultations ............................................................. 28  
    Interaction in Dental Consultations ............................................................. 29
Analysis .........................................................................................................................31

Task-Oriented First Turns ............................................................................................32

Exam initiation in follow-up visits ..............................................................................32

Treatment plan formulation in follow-up visits .........................................................34

Inviting no-problem confirmation in follow-up and routine visits .........................38

Inviting problem elaboration in new-concern visits ..............................................44

Non-Task-Oriented First Turns ..................................................................................48

Summary and Discussion ............................................................................................52

Chapter 5: Achieving Activity Transitions in Dentist-Nurse-Patient Encounters ......56

Introduction ................................................................................................................56

Background ................................................................................................................58

Activity Transitions in Physician-Patient Encounters ..............................................58

Inter-Professional Collaboration in Clinical Settings .................................................60

Analysis ......................................................................................................................63

Transitions Accomplished Tacitly ..............................................................................64

Transitions Accomplished through Talk ...................................................................70

Nurse’s announcement of drape placement ...............................................................71

Dentist’s announcement of exam initiation ‘before’ patient’s face is covered ..........76

Dentist’s announcement of exam initiation ‘after’ patient’s face is covered ..........88

Summary and Discussion ............................................................................................98

Chapter 6: Delivering Evaluations of Patients’ Oral Hygiene ..................................101

Introduction ..............................................................................................................101
LIST OF FIGURES

Figure 1: Dentist (left), patient (center), and nurse (right) in the treatment room .............19
Figure 2: Patient (left) and dentist (right) in the waiting area .....................................20
Figure 3: The nurse (right) covers the patient's (center) face with a drape, while the
dentist (left) picks up a dental mirror .................................................................64
Figure 4: The dentist holds the mask straps to tie .....................................................66
Figure 5: The nurse turns on the exam light ..............................................................67
Figure 6: The nurse unfolds the drape ..................................................................68
Figure 7: The nurse raises the drape to cover the patient's face .................................73
Figure 8: The nurse takes hold of the drape ..............................................................77
Figure 9: The nurse unfolds the drape ..................................................................78
Figure 10: The dentist looks at the chart .................................................................82
Figure 11: The nurse takes hold of the drape ..............................................................85
Figure 12: The dentist touches the drape ..................................................................86
Figure 13: The nurse covers the patient's face .........................................................86
Figure 14: The nurse takes hold of the drape ..............................................................89
Figure 15: The nurse raises the drape upward ...........................................................90
Figure 16: The dentist holds mask straps to tie ........................................................90
Figure 17: The nurse retracts her right hand .............................................................91
Figure 18: The nurse retracts her right hand again ....................................................91
Figure 19: The nurse starts to cover the patient's face ............................................92
Chapter 1: Introduction

Dental Visits in Korea: Contextual and Cultural Particularities

Maintaining oral health is essential for our quality of life. Poor oral health not only affects physical well-being but also influences self-esteem and self-image. And yet, visiting the dentist is often a stressful and unpleasant experience. Research in dentistry has shown that patients commonly experience anxiety and stress in dental settings mostly due to fear of pain during dental treatment (McNeil & Berryman, 1989). Feelings of shame and guilt associated with poor dental condition were also found to be factors facilitating avoidance of dental care (Berggren & Meynert, 1984; Moore et al., 2004). Thus, good communication between dentist and patient is important as it is linked to reduced patient anxiety and better oral health outcomes (e.g., Rouse & Hamilton, 1990; Sinha et al., 1996; Street, 1989; Yamalik, 2005).

Although there is a large body of research on medical consultations, communication in dental settings has been relatively under-investigated. Dental consultations differ from other types of medical consultations in several important ways. First, there is actual delivery of treatment. Being exercised in the mouth, with patients lying in a dental chair and practitioners looking down their face from above, the treatment significantly hinders verbal interactions between practitioners and patients. Second, patients’ dental health status is often seen as reflective of their own self-care behaviors, such as tooth brushing, flossing, and regular dental checkup. Dentists and patients regularly discuss patients’ lifestyle behaviors in connection with their dental condition (cf. Silverman, 1993). Third, a dental assistant is routinely present to help the dentist perform the treatment, which makes triadic interaction as the norm in dentistry.
(cf. Bridges et al., 2015). This can add complexity to the interaction in dental settings compared to dyadic doctor-patient interaction. Overall, these distinctive features can emerge as a differentiated form of communication that is specific to dental contexts. In this dissertation, I aim to advance our understanding of the specific tasks and activities that make up the dental visit, adding to the small body of literature on the organization of dentist-nurse-patient interaction.

Another unique aspect of this dissertation is its concern with culturally specific features of Korean medical interaction. Korea has universal health insurance coverage, and patients can visit any physicians, specialists, or hospitals that they choose. This makes ‘doctor shopping’ prevalent in Korea, and thus competition among doctors is very strong. Importantly, under the fee-for-service reimbursement system, doctors are financially incentivized to see more patients, and thus they try to spend less time on each consultation (Cho et al., 2004). Research on doctor-patient communication in Korea has pointed out the negative impacts of insufficient consultation time and quick patient turnover on quality of care, such as unmet information needs (Chae et al., 2019). Although the recent movement in Korea to adopt patient-centered care argues for the need for an extended consultation time, according to the Organization for Economic Co-operation and Development (OECD, 2019), the number of consultations per doctor in Korea is still the highest among OECD countries and the time spent with patients during consultation is 16th among 21 countries.

In addition, compared to doctor-patient relationship in other cultural contexts, in Korea, physicians tend to adopt dominant roles, with patients being passive recipients (e.g., Kim et al., 2004; Kim & B. Park, 2008). Physician-patient interaction in Korea is
characterized as doctor-oriented, with physicians having control over medical information and maintaining authority in their relationship with patients (Kim & B. Park, 2008). Moreover, doctors in Korea normally use communication practices that discourage patients from full disclosure of their concerns (Y. Park, 2013, 2017). Given these characteristics that are in conflict with the recent movement for patient-centered care, some researchers are skeptical about whether a patient-centered communication style – which promotes patient participation and involvement – can readily be used in Korean healthcare contexts. Since Korean patients are accustomed to their institutionalized passive roles, simply encouraging their participation and involvement could make them uneasy and even distrustful of doctors’ recommendations (Kim et al., 2004; see also Y. Park, 2009). Thus, to consider best practices to be applied in Korean healthcare contexts, it is crucial to understand the precise mechanisms through which Korean providers and patients organize their interaction, rather than simply advocating for an ‘ideal’ style of interaction.

This dissertation aims to contribute to advancing our understanding of the endogenous mechanisms through which dentists, nurses, and patients organize their interaction in Korean dental visits. Using video-recordings of routine dental consultations in Korea, I analyze the actual conduct of participants and uncover the particular ways in which tasks and activities are accomplished. By presenting a detailed analysis of dentist-nurse-patient interaction in Korea, this dissertation will shed light on the specialty- and culture-specific practices as well as the generic practices of social interaction.
Overview of the Dissertation

The structure of this dissertation is as follows. In Chapter 2, I will present a review of the literature on patient-centered communication and the conversation analytic literature on medical encounters. I will then explore some specialty and cultural aspects of Korean dental visits by reviewing research on dentist-patient communication and on Korean medical consultations, respectively. In Chapter 3, I will discuss the data and methodology that are used in this dissertation.

In Chapter 4, I will examine the early moments of dentist-patient interactions, focusing on the dentist’s very first turn-at-talk. I will show that the dentist uses either a task-oriented or a non-task-oriented first turn to initiate the interaction. Task-oriented first turns are designed to facilitate the move towards the dental examination and treatment by conveying the dentist’s prior knowledge about patients’ dental problems. Non-task-oriented first turns enact the dentist’s familiar relationship with patients, initiating a social/personal opening and postponing the launch of the dental business. I will propose that these interactional trajectories are related to the distinctive features of Korean culture, on the one hand, and to the unique aspects of dental consultations, on the other.

In Chapter 5, I will examine how dentist, nurse, and patient collaborate to accomplish the transition into the activity of dental examination. Activity transitions can be accomplished tacitly, i.e. without explicitly referring to the examination, because participants can project and anticipate next steps of exam preparation by monitoring each other’s talk, bodily conduct, and object manipulation. However, dental professionals explicitly refer to the examination when they anticipate a delay in the other parties’ cooperation. I will show that participants accomplish transitions smoothly by orienting both to local contingencies and to the routine trajectory of the transition.
In Chapter 6, I will examine how the dentist presents ‘good’ and ‘bad’ oral hygiene results to patients. While positive oral hygiene evaluations are delivered straightforwardly and without delay, negative evaluations are not stated outright. The dentist shows intraoral photos – images taken by the intraoral camera to capture dental problems – to patients with poor oral hygiene so as to inform them about their oral hygiene status. I will propose that, with this ‘show don’t tell’ approach, the dentist avoids conveying an overt judgment about patients’ poor self-management while motivating them to engage in self-care.

Finally, in Chapter 7, I will summarize the findings of the dissertation, consider the implications of the findings, discuss the limitations of the dissertation project, and make suggestions for future research.
Chapter 2: Literature Review

Health communication research on provider-patient interaction across a variety of healthcare contexts has focused on how patients perceive their communication with providers, highlighting the importance of patient-centeredness. However, it is not clear what ‘patient-centered’ communication looks like in practice and whether it is always desired by patients. Research in the field of conversation analysis has investigated how providers and patients co-construct their interaction in real time, focusing on their displayed orientations to each other’s conduct and to their roles and relationships. Using a conversation analytic approach, this dissertation builds upon prior work on provider-patient interaction by examining how dentist, nurse, and patient jointly construct the dental visit in Korea. In what follows, I will begin by providing a brief overview of the literature on patient-centered communication, and then review previous conversation analytic literature on medical encounters. Finally, I will review research on dentist-patient communication and on doctor-patient communication in Korea, respectively, to understand some specialty and cultural aspects that are unique to Korean dental contexts.

Patient-Centeredness, Therapeutic Alliance, and Provider-Patient Communication

With the adoption of consumerist model of medicine, a growing body of healthcare literature highlights the importance of patient-centeredness for the delivery of quality care, although the concept has been interpreted in various ways by scholars and clinicians (Epstein et al., 2005; Mead & Bower, 2000; Stewart et al., 2000). The Institute of Medicine (IOM, 2001) identifies patient-centeredness as one of six aims for health care improvement, defining it as “providing care that is respectful of and responsive to individual patient preferences, needs and values” (p. 6). Mead and Bower (2000) describe
five key dimensions of the concept of patient-centeredness, which include consideration of psychological factors of illness, understanding the patient as an individual, inclusion of the patient in making medical decisions, developing a therapeutic alliance, and awareness of the influence of doctor subjectivity. In research on provider-patient interaction, patient-centered communication has been advocated as an ideal style of consultations and linked to various positive patient outcomes (Smith, 2002; Stewart et al., 2003).

In general, providers’ behaviors that are typically considered as patient-centered include using open-ended questions, paying attention to patients’ concerns, and encouraging patients to express their needs and preferences (Epstein et al., 2005; Howie et al., 2004). Byrne and Long (1976) describe consultation styles that make up a continuum ranging from doctor- to patient-centered, based on their observation of audiotaped consultations. Doctor-centered styles are those that limit patient participation in decision making, with behaviors such as closed questioning and giving directions; whereas patient-centered styles are those that promote understanding of patients’ needs and concerns, with open questioning and encouragement of patient participation (Byrne & Long, 1976). Patient-centeredness has also been conceptualized as allowing patients to express all of their reasons for the visit (Henbest & Stewart, 1989). Based on the biopsychosocial perspective, scholars have argued that patient-centeredness requires addressing the full range of patients’ concerns, including non-medical aspects of problems (Grol et al., 1990; Stewart et al., 1995).

Developing a ‘therapeutic alliance’ – which is based on the personal bond between providers and patients and a common understanding of therapeutic goals – is also an essential component of patient-centered care (Mead & Bower, 2000). A
substantial body of healthcare research has shown the effects of a trusting therapeutic relationship on patients’ health, emphasizing the role of communication in the formation of such relationship (Pinto et al., 2012). Based on interviews with patients, DiMatteo, Prince, and Taranta (1979) show that patients are more likely to return to their physician and commit to the therapeutic relationship when their physician communicates caring and concern. Providers can also facilitate successful relationship building by delivering clear information about treatment options and inviting patients to take an active role in decision making, which leads to improved patient adherence (DiMatteo, Reiter, & Gambone, 1994). Inclusion of patients through information exchange and shared decision-making has particularly been emphasized in the healthcare literature with regard to the formation of the therapeutic bond and its effects on patient health behaviors, such as treatment adherence.

Yet, while patient-centered communication highlights patient autonomy and control, studies indicate that such communication style may not always be desired by all patients. In a survey conducted by Degner et al. (1997), approximately one third of patients with breast cancer responded that they want to delegate the responsibility for making treatment decisions to their physicians. Other studies based on survey questionnaires show that older patients prefer to have their doctors, rather than themselves, make treatment decisions, which may be due to fear of making a wrong decision (Thompson et al., 1993; Vick & Scott, 1998). In Savage and Armstrong’s (1990) experimental study, general practice patients with simple physical illness were more satisfied with a directing style of consultation than a sharing style. Furthermore, providers may sometimes choose not to be ‘patient-centered’ for better health outcomes. Ratings of
audiotaped consultations show that providers become more directive and controlling when communicating with patients who do not adhere to the prescribed regimen and maintain unhealthy lifestyles (Lawson, 2002). Thus, Krupat et al. (2000) argue that it is important for providers to recognize the preferred role orientation of patients and be flexible in their style of interaction with patients.

Healthcare professionals have been encouraged to adopt patient-centered care, but the challenge of defining patient-centered practices remains. While it seems evident that patients value feelings of being cared for, understood, and listened to, exactly how this can be achieved in provider-patient interaction seems less clear. Furthermore, both providers and patients enter into medical consultations with some role expectations – which may vary across visit types, individual characteristics, cultures, and other factors – but at the same time they constantly negotiate their roles and relationships in the process of interaction (Mikesell, 2013; Pomerantz & Rintel, 2004). Providers and patients manifest their orientations to who they are to each other in what they say and do, and together construct their relationship in the course of interaction. An examination of how both parties enact their roles and relationships moment-by-moment in consultations can contribute to a better understanding of the evolving provider-patient relationship as well as improving communication and health care.

**Conversation Analytic Research on Medical Encounters**

Research in the field of Conversation Analysis (CA) has comprised a notable portion of studies on provider-patient interaction across disciplines (Heritage & Maynard, 2006). Based on the notion that every social interaction is structurally organized so that “no order of detail can be dismissed, *a priori*, as disorderly, accidental or irrelevant”
CA research has contributed to discovering the systematic ways in which tasks and activities are managed in medical encounters. Using video/audio-recordings of naturally occurring medical interactions, conversation analysts examine the observable conduct of providers and patients, i.e., what participants themselves are doing right then, and the institutional roles and relationships enacted in situ in the course of interaction (see Chapter 3 for a more in-depth discussion). Given the vast CA literature on provider-patient interaction, in this section, I will only present a selective overview of the studies that are most relevant to this dissertation.

CA research has uncovered the *overall structural organization of medical visits*, showing that medical visits are composed of recurrent phases of activity that are normatively ordered. Building on Byrne and Long’s (1976) pioneering work that identified six phases of medical consultations (i.e., opening, problem presentation, history-taking and/or examination, diagnosis, treatment, and closing), CA studies have explicated how physicians and patients orient to and manage the orderly progression through these phases. In particular, it has been shown that doctors and patients interactionally collaborate to navigate activity boundaries through talk and bodily conduct. For instance, during openings of consultations, physicians and patients orient to each other’s gaze and body orientation to negotiate their readiness to discuss the chief complaint (Heath, 1986; Robinson, 1998; see Chapter 4 for a discussion of the openings of medical consultations). Furthermore, upon seeing physicians prepare examination-relevant tools, patients usually change their posture to ready themselves for the physical examination, even without overt instruction to do so (Robinson & Stivers, 2001; see Chapter 5 for a discussion of how activity transitions are accomplished in medical
Robinson and Stivers (2001) propose that, although patients are able to properly respond to physicians’ transition-relevant bodily conduct, physicians’ overt verbal explanations can help reduce patients’ uncertainty regarding the activity-flow of the encounter.

CA research has also described the interactional practices through which providers solicit patients’ medical concerns, suggesting ways to improve provider-patient relationships and health outcomes. For instance, Heritage and Robinson (2006) show that, when providers open the business of the visit, general inquiry questions (e.g., “What can I do for you today?”) invite more extensive problem presentation from patients than confirmatory questions (e.g., “I see you have sinus problems?”) do. This is because general inquiries show that doctors are agnostic about the reason for patients’ visits whereas confirmatory questions assume doctors’ prior knowledge about patients’ problems (see Chapter 4 for a discussion of providers’ opening solicitations of patients’ concerns). Since an extensive problem description of patients can lead to improved diagnosis and treatment, the authors suggest that practitioners should use general inquiries even if they have already received the information about patients’ problems from the medical assistant beforehand (see also Heritage, 2011). Furthermore, when doctors follow up to solicit additional concerns, questions containing the positive polarity item ‘some’ (e.g., “Do you have some other concerns you would like to discuss today?”) significantly reduce patients’ unmet concerns compared to those containing the negative polarity item ‘any’ (Heritage et al., 2007). Overall, by explicating how doctors’ questions shape subsequent interaction, CA research has identified interactional practices for improving health outcomes.
Some of the CA work on the activity of *delivering diagnosis* has explored how healthcare providers handle interactional dilemmas and local contingencies through various sequential and turn-design features. Maynard (1991) shows that clinicians deliver ‘bad’ diagnostic news by initiating a pre-sequence to the news delivery sequence to prepare patients for an adverse diagnosis (Maynard, 1991). Instead of immediately announcing the news, clinicians invite patients to describe their own view of the medical problem so as to confirm patients’ perspective and use it to affirm the diagnostic announcement (see Chapter 6 for a discussion of practices through which ‘good’ and ‘bad’ oral hygiene evaluations are delivered). In addition, doctors design their diagnostic turns differently (e.g., plain assertions vs. references to evidence) to communicate different levels of certainty and medical reasoning, treating themselves as accountable for the grounds of their diagnoses (Peräkylä, 1998; see Chapter 6 for a discussion of different forms of oral hygiene evaluations). Thus, through the detailed analysis of how turns and sequences are designed to deliver diagnostic news, these studies show participants’ “sensitivities to the medical and interactional exigencies in play” (Heritage & Maynard, 2006, p. 18).

With the detailed analysis of interactional patterns and practices, CA research has described the taken-for-granted ways by which providers and patients coordinate actions and enact their roles and relationships in medical encounters. Based on the systematic description of the interactional phenomena – which providers and patients themselves may not be fully aware of – solutions have been suggested to interactional problems that are fundamentally rooted in conventions of everyday social life (Heritage & Maynard, 2006). Yet, although the field of CA has yielded many studies on provider-patient
interaction across various medical specialties and cultures (see Stivers & Barnes, 2018), still much research is needed to uncover practices used in dentistry and in Korean healthcare settings. In what follows, I review previous research on dentist-patient communication and on Korean medical encounters, respectively, to explore some contextual and cultural particularities of Korean dental settings.

**Research on Dentist-Patient Communication**

Studies investigating dentist-patient communication have highlighted the importance of treating patients as individuals in their own right, advocating for patient-centered care. Especially in dental consultations, many patients experience anxiety and fear of pain during dental treatment (e.g., McNeil & Berryman, 1989; Smith & Heaton, 2003) and feelings of shame and guilt due to their poor oral health condition (e.g., Moore et al., 2004). Thus, it has been argued that dental practitioners should make a ‘connection’ with patients on a human level by showing empathy and emotional understanding (e.g., Kulich et al., 2003; Loignon et al., 2010; Scambler et al., 2011). Dentists are suggested to implement an expanded role that includes paying attention to the psychosocial well-being of patients so as to establish long-standing relationships and provide successful dental treatment (Dworkin, 2001).

Much of the communication literature on dentistry has explored patients’ perceptions of dental encounters by using questionnaire/survey or interview methods. In general, studies have shown that dental patients report higher satisfaction with the care they receive when providers attend to their feelings, concerns, and opinions (e.g., Corah et al., 1988; Fico & Lagoe, 2018; Wong et al., 2017; Sinha et al., 1996; Street, 1989). Specifically, patients’ anxiety is reduced and satisfaction is increased when they perceive
that dentists give reassurance and opportunities to discuss their fears (e.g., Corah et al., 1988; Sinha et al., 1996; Street 1989). When asked about positive and negative communication experiences, patients most frequently reported dentists’ management of anxiety/physical discomfort as a positive behavior and dentists’ disregard for their concerns/feelings as a negative behavior (Fico & Lagoe, 2018). Furthermore, providers’ attitude toward patients’ oral health condition can affect patients’ feelings of guilt and shame which lead to anxiety (Moore et al., 2004). According to Gale (1972), patient anxiety is intensified when, for instance, dentists laugh during dental examination or tell patients that they have bad teeth. Overall, it seems to be important that dental providers address patients’ fears, anxiety, and discomfort effectively, especially given that dental examination and treatment can be uncomfortable or painful.

In addition, surveys and interviews with dental patients show that they feel empowered and motivated when encouraged to participate in the decision-making process (e.g., Benecke et al., 2020; Wong et al., 2017). Yet, according to Benecke et al. (2020), when compared to patients in other healthcare settings, dental patients show a weaker preference to be involved in the decision-making process, with a marginal majority preferring a passive role. Also, the degree to which dental patients want to participate in treatment decisions may change depending on the situation: Patients’ desire for participation seems to decrease when they have severe pain and increase when they lose confidence in the dentist (Chapple et al., 2003). Thus, what seems to matter is that dental providers meet each patient’s preferred level of participation because “role preference is not a static entity, but rather develops and changes according to circumstances and experiences” (Chapple et al., 2003, p. 327).
Overall, research focusing on patients’ perceptions of dental encounters has shown that patients commonly experience anxiety about dental procedures and thus want their providers to give encouragement and reassurance. Although the studies above inform us about the type of behavior certain patient populations want from their dental provider, this may not be enough to meet the varying needs of individual patients. More importantly, not much is known about how providers and patients accomplish dental activities interactively and in a locally situated way. What remains to be explained is how interaction actually works in dental consultations, including the precise ways in which providers’ conduct shapes and constrains patients’ conduct on a moment-by-moment basis. To understand the nature of dental encounters, and to find ways to improve dental care, it is crucial to understand what precisely is involved in actual, real-time interaction in dental settings.

In the field of conversation analysis, a growing, albeit still limited, body of research has investigated interactions in dental settings, throwing light on how medical tasks are accomplished in dental interaction. Anderson (1989) identifies routine components that constitute the activities of dental examination and anesthetic administration. To begin the inspection of the patient’s mouth, for instance, dentists first specify what they are going to do (e.g., “Let me see”), request the patient to open the mouth (e.g., “Open for me if you could?”), and produce an assessment to close the sequence (e.g., “That’s good”) (see Chapter 5 for a discussion of how dental examination is initiated in Korean dental visits). In the context of dental training and education, student dentists use bodily conduct – such as handling of tools or holding a posture – to demonstrate their understanding of supervisors’ comments (Hindmarsh, 2010; Hindmarsh
et al., 2011). In multilingual dental encounters in Hong Kong, dentists and dental assistants collaborate to provide interpretations to patients while performing dental activities (Bridges et al., 2015). These studies have elucidated the organization of interaction in dental settings as well as some distinctive features of dental tasks, such as the particularities of the dental examination activity, body postures involved in the practice of dentistry, and the process of triadic interaction between dentist, nurse, and patient. However, with such a limited body of research, much more remains to be explored to advance our knowledge of communicative practices used in dental visits.

**Research on Doctor-Patient Communication in Korea**

Research on healthcare interaction in Korea has identified problems of a paternalistic doctor-patient relationship that is prevalent in Korea, advocating for patient-centered care (e.g., Gong et al., 2011; Kim & B. Park, 2008; S. Park et al., 2021). Interviews and surveys with patients in Korea indicate that patients perceive their physicians’ communication style as dominant rather than empathic, although they are more satisfied with physicians with empathic communication styles (Kim & B. Park, 2008). More specifically, patients in Korea perceive their physicians to take a high level of control over the interaction and discourage patients’ involvement, rather than to be friendly, caring, and warm. An analysis of videotaped physician-patient interactions using coding methods also reveals a lack of Korean physicians’ empathic behaviors (e.g., active listening, supportive talks), which discourages patients from asking questions and expressing concerns or demands (Chang et al., 2013). These studies note that the dominant communication style of Korean physicians is in conflict with the recent
consumerist movement, claiming the need for a training program that improves doctors’
empathic skills.

Whereas the studies above explore how patients perceive doctors’ communication
styles or how frequently particular communicative behaviors occur in a consultation,
conversation analytic studies on Korean medical encounters have revealed the systematic
patterns of communication that are specific to Korean contexts. In particular, research has
suggested that primary care visits in Korea progress more rapidly through consultation
phases than those in the US and UK (Y. Park, 2009, 2013, 2017). In openings of primary
care visits in Korea, greeting sequences are combined with the tasks of having patients
seated or identifying patients (Y. Park, 2017). Also, physicians’ opening question –
which has the form of “Where does it hurt?” – constrains patients’ response to a single
unit that identifies the location of pain (Y. Park, 2017). When closing the visit, physicians
orient their gaze toward the computer screen and their body toward the desk to
discourage patients from raising additional concerns (Y. Park, 2013). According to Y.
Park (2017), these practices partly have to do with the Korean healthcare system which
encourages doctors to have quick patient turn-over as well as to a cultural expectation for
a ‘rapid’ accomplishment of tasks in Korean institutional encounters (see also Bailey,
2000).

Overall, medical consultations in Korea have been characterized as terse,
business-oriented (rather than empathic), and expeditious in its progression. Research on
Korean medical encounters, however, is still relatively underdeveloped (see also Lee &
Kim, 2015, 2019 for conversation analytic research on emergency care visits in Korea),
and much more remains to be discovered about the interactional patterns and practices
through which medical activities are done. Also, various medical specialties, including dentistry, need further investigation. This dissertation provides a detailed analysis of the endogenous organization of dental visits in Korea to understand how Korean dental care is “talked into being” (Heritage, 1984, p. 290), i.e. how providers and patients collaborate in doing dentistry. My analysis will provide the necessary empirical basis for future applied work towards improving the delivery of dental care.
Chapter 3: Data and Methodology

Data and Setting

The data for this dissertation were collected in 2016 at a private dental clinic located in a satellite city of Seoul in South Korea. Routine dental interactions between patients, nurses, and the dentist were video-recorded. Video-recordings of 101 dental consultations (a total of approximately 14 hours) were collected, which include 1 dentist, 4 nurses, and 82 patients. All dental consultations take place in the treatment room, which is separate from the waiting area and the dentist’s office. During the consultation in the treatment room, the patient is lying on a dental chair, the dentist sits on the right side of the patient, and the nurse stands on the left side (Figure 1). The dentist and the patient sometimes interact in the waiting area before the patient leaves the clinic to briefly discuss the results of the examination and treatment and how to perform self-care at home (Figure 2). 11 among 101 video-recordings include the dentist-patient interaction that occur in the waiting area. The study was approved by the Rutgers Human Subjects Review Board, and informed consent was obtained from all participants.

Figure 1: Dentist (left), patient (center), and nurse (right) in the treatment room
All video-recordings were transcribed according to the conversation analytic
cKeyValue
conventions (Hepburn & Bolden, 2017) (see Appendix A for transcription conventions).
Embodied actions were transcribed following conventions developed by Mondada
(2014a) (see Appendix B for multimodal transcription conventions). Any identifying
information about the participants (e.g., names) has been changed in the data extracts.
Transcripts have three lines for the Korean language (Hepburn & Bolden, 2017). The first
line provides romanized Korean according to the Yale system, representing spoken
Korean words. The second line is an English translation of each word with a morpheme-
by-morpheme gloss (see Appendix C for the classification and abbreviation of
grammatical morphemes). The third line is an idiomatic English translation.

In the dental clinic where the data were collected (as is typical in Korea), patients’
chief complaints are documented in scheduling rosters and medical records when making
appointments. The dentist has access to this information, prior to the consultation,
through the computerized records and/or the chart. Typically, a patient is taken to the
treatment room by a nurse and is seated in a dental chair. The nurse lowers the chair into
a reclining or a fully horizontal position, and prepares a drape to cover the patient’s face. The use of the face drape is common in Korean dental clinics: It prevents patients from gazing directly at the examination light and protects their facial area from splashes of fluids during the treatment. The drape is put on the patient’s chest before the examination begins because once the patient’s face gets covered, it becomes difficult for the patient to interact with the dentist. The nurse calls the dentist in (from his office), and the dentist-patient encounter begins as the dentist approaches the patient.

**Methodology**

This dissertation employs the methodology of conversation analysis (Atkinson & Heritage, 1984; Sidnell & Stivers, 2013). Conversation Analysis (CA) is a method for studying social interaction based on the assumption that talk-in-interaction is the “primordial site of human sociality” (Schegloff, 2006, p. 70). It aims to document and describe the sense-making practices that participants use in everyday social interaction. CA insists on using recordings of naturally occurring interaction to observe the details of actual conduct and to “start with things that are not currently imaginable, by showing that they happened” (Sacks, 1984, p. 25). With its thoroughly bottom-up approach, CA analyzes participants’ orientations that are displayed in the naturally produced data. Findings are generated not “from some theoretical formulation of what should be studied” but from what is made relevant and oriented to by participants themselves (Sacks, 1984, p. 26). CA focuses on the moment-by-moment unfolding of interaction, with an assumption that every turn in conversation is produced in the context of the prior turn and shapes another context for the next turn (Schegloff, 1968; Schegloff & Sacks, 1973). Based on this notion of context, what participants say and do is analyzed by
reference to what came before, i.e. the sequential position in which the utterance is produced.

Emerging as a field in the late 1960s, CA initially focused on analyzing structures of everyday, mundane social interaction, such as telephone calls between friends and family. The subfield of institutional CA examines the distinctive features of talk in institutional contexts, such as medical consultations, compared to ordinary conversation (Drew & Heritage, 1992). Based on the fundamental notion that there is “order at all points” in talk-in-interaction (Sacks, 1984, p. 22), medical CA research has contributed to explicating patterns of communication that structure medical visits as well as specific elements of providers’ and patients’ conduct. Essentially, CA research on provider-patient interaction assumes that persons’ use of ordinary interactional practices is a part of human ‘habitus’ (Heritage, 2011), and therefore those practices “are not abandoned at the threshold of the medical clinic” (Heritage & Maynard, 2006, p. 13). The specifics of institutional conduct in medical interaction are therefore viewed as modifications of ordinary practices for particular tasks and as part of “the natural living order of social activities” (Mondada, 2013, p. 34). With this view of CA, detailed descriptions of providers’ and patients’ interactional practices – which are profoundly rooted in their everyday lives – could be provided.

CA analysis of medical encounters is conducted through three interrelated levels: (1) the overall structure of the medical visit, (2) the sequence organization through which activities are managed, and (3) the turn design through which actions are implemented (Drew & Heritage, 1992; Heritage & Maynard, 2006). First, the overall structural organization of medical visits is composed of recurrent phases of task-focused activity.
For instance, acute primary care visits are routinely consist of opening, problem presentation, history-taking and/or examination, diagnosis, treatment and closing (Byrne & Long, 1976). Conversation analysts rely on this structural framework to the extent that providers and patients orient to it as they jointly manage the progression of the medical visit. Second, sequence organization is based on the notion that a series of actions produced through turns-at-talk can be grouped or ‘hang together’ with some continuity or coherence (Schegloff, 2007). This notion is premised on the recognition that an action in interaction can normatively require a reciprocal next action from another speaker and can form the basic unit of adjacency pairs (e.g., greeting-greeting or request-grant/denial). Understanding how providers’ and patients’ utterance achieves its meaning in interaction inevitably involves appreciating the principles of sequence organization. Third, the analysis of turn design addresses participants’ selection of an action and the verbal composition of a turn (Schegloff, 2007). Turn design is a significant arena in analyzing action formation since participants choose to perform an action and verbalize it in a particular way through the practices of turn design. Overall, these levels of analysis not only enable CA’s systematic approach to medical interaction but also make it possible to unravel various interactional dilemmas – which cannot be solved without a precise understanding of how interaction works in medical consultations.

CA methodology has also been suggested to have cross-cultural and cross-linguistic applicability. While CA emerged from the investigation of English-language interactions, recent studies within the field have examined a large number of other languages, including Korean, Japanese, Mandarin, Spanish, Russian, and Finnish, just to name a few. On the one hand, these studies illustrate the diversity of conduct by showing
members’ orientations to their cultural norms and their adoption of language-specific resources, which can be distinguishable from those exhibited in ‘English-language’ interactions (Sidnell, 2009). On the other hand, cross-cultural and cross-linguistic CA studies have also shown the commonalities of conduct, suggesting that every human interaction faces the same sorts of organizational problems that require similar solutions (Levinson, 2006; Schegloff, 2006; Sidnell, 2009). Hence, the CA methodology can be used to uncover different cultural norms and orientations as well as common interactional problems that are resolved through the mobilization of semiotic resources in a given language (Schegloff, 2006).

For this dissertation, the recorded dental consultations were analyzed inductively in accordance with the CA methodology. Through close and repeated examination of the video recordings and transcriptions, I identified three recurrent and distinctive phenomena in my data corpus – how dentist-patient interactions begin (Chapter 4), how the activity of dental examination begins (Chapter 5), and how oral hygiene evaluations are delivered to patients (Chapter 6). I began examining the collection of instances I had made for each of these phenomena. A case-by-case analysis of each instance yielded broad categories of practices, which were grouped into sub-collections. For instance, I categorized the dentist’s initial turns-at-talk into task- and non-task-oriented ones; the type of activity transition based on whether the transition is explicitly referred to by participants or not; and the oral hygiene evaluations into positive and negative ones based on the different interactional structures through which they are delivered. Finally, I developed my analysis by focusing on how the target phenomenon is composed of and what participants accomplish through the practices that constitute the phenomenon.
Chapter 4: The Dentist’s First Turn-at-Talk in Korean Dental Visits

Introduction

Openings of interaction are important locus in which participants constitute social relationships and coordinate entry into a joint activity (Goffman, 1967; Pillet-Shore, 2008; Schegloff, 1986). Conversation analytic (CA) research has shown how participants establish the nature of their social relationship and of their encounter during openings of interactions in a variety of settings (e.g., Heath, 1981; Robinson, 1998; Mondada, 2009; Pillet-Shore, 2012, 2018). However, little research has investigated the openings of dental consultations despite the distinctive features of dental interactions. Since dentists administer treatment during the consultation, how they initiate their encounter with patients may relate to the upcoming treatment procedure (Coleman & Burton, 1985). Furthermore, unique body arrangements are involved because patients are seated in a dental chair surrounded by the machinery and equipment when dentists arrive to begin the interaction. In this chapter, I aim to reveal particular and recurrent features of the early moments of dental consultations by focusing on the dentist’s very first spoken utterances.

Another contribution of the analysis presented in this chapter is to reveal culturally specific features of medical interaction in Korea. Previous research has shown that primary care visits in Korea tend to proceed ‘rapidly’ compared to those in the US and UK. Typical consultation phases are often reduced or minimized, and physicians solicit patients’ problems in a way that constrains their response to a single unit that identifies the location of pain (Y. Park, 2017). During the closing phase of the visit, physicians display bodily conduct that discourages patients from raising additional
concerns (e.g., directing gaze toward the computer screen) (Y. Park, 2013). Y. Park (2017) claims that these interactional practices have to do with the Korean healthcare system that encourages doctors to spend less time on each consultation. This chapter sheds further light on aspects of Korean healthcare communication by examining the previously unstudied medical specialty – dentistry.

This chapter is organized as follows. I first review the literature on conversation openings in general, openings of medical consultations, and interaction in dental consultations. Then, I analyze different interactional practices the dentist uses to design the very first turn in the encounter with patients. My analysis shows that the dentist may produce a task-oriented turn right after he arrives and sits next to the patient, going straight to the business at hand and expediting the move towards the dental examination and treatment. Alternatively, the dentist may produce a non-task-oriented first turn to have a more social/personal opening, postponing the move to dental business. The findings contribute to CA research on openings by providing the first detailed analysis of the initial moments of dentist-patient encounters. The findings also add to the CA literature on provider-patient communication across cultures and across medical specialties (see Stivers and Barnes, 2018) by revealing the distinctive aspects of Korean medical culture and dentistry in particular.

**Background**

*Conversational Openings*

Conversation analytic (CA) research has investigated how interactants enact their social relationship and establish the nature of their encounter in the initial moments of interactions. In early CA work on telephone openings, Schegloff (1968) showed how
participants achieve a routine opening by establishing access and mutual identification, exchanging greetings and ‘how-are-you’s, and moving to the “first topic” that constitutes the reason for the call. CA studies have also examined openings of face-to-face encounters in a variety of settings, describing how participants establish mutual gaze and a spatial and physical alignment (e.g., De Stefani & Mondada, 2018; Mondada 2009); communicate that their readiness to deal with the reason for the encounter (e.g., Heath, 1981; Kidwell, 2018; Robinson, 1998); display a stance toward their relationship through prosodic features of greetings (e.g., Gan et al., 2020; Pillet-Shore, 2012; Schegloff, 1998b); and join the interaction-in-progress (e.g., Pillet-Shore, 2018). Altogether, these studies have demonstrated that participants utilize the opportunities available in the early moments of interactions to negotiate who they are to one another and what their encounter will be about.

Pillet-Shore (2018) developed an empirical inventory of modular components of face-to-face openings. According to the inventory, during openings, participants establish co-presence through summoning actions; ratify each other’s presence through greeting utterances (e.g., “Hi”, “Hello”) and gestures (e.g., hand wave); coordinate physical touch (e.g., handshaking); identify themselves; exchange information about how they are doing or what they have been doing; establish joint attention to publicly perceivable features (e.g., how they look); make themselves and their environment ready for a joint activity (e.g., sitting down); and formulate the amount of time elapsed since their last interaction. Although not all these components are always present, interactants recurrently draw on these resources to enact, for instance, their stance towards the specialness of the current encounter (Pillet-Shore, 2018). Furthermore, openings of ordinary interactions are
adapted, reduced, and specialized in institutional settings (e.g., Wakin & Zimmerman, 1999) in ways that demonstrate participants’ orientations to institutional tasks and goals.

**Openings of Medical Consultations**

Prior studies have revealed that the overall structure of a medical consultation is typically composed of opening, problem presentation, history taking and physical examination, diagnosis, treatment, and closing (Byrne & Long, 1976; Robinson, 2003; Waitzkin, 1991). The opening phase is initiated when doctors and patients establish co-presence and is terminated when doctors solicit patients’ chief complaint, i.e. when the problem presentation phase is initiated. During openings, preliminary activities are carried out that are necessary to launch the business of the visit: Greetings are exchanged, a proper spatial and physical alignment is achieved, and doctors check patients’ identity and read their medical records (Byrne & Long, 1976; Heath, 1981, 1986; Robinson 1998). To achieve a smooth transition into the business phase of the visit, doctors and patients monitor each other’s talk and bodily conduct so that they can discern each other’s readiness to begin (Heath, 1986; Robinson, 1998).

Medical openings are also a site for exchanging off-task conversation, i.e. verbal exchanges that are not strictly related to the institutional business (Coupland, 2000). In openings of geriatric consultations, for example, doctors and elderly patients are routinely engaged in “socio-relational talk”, such as discussing the weather or exchanging ‘how-are-you’s, prior to dealing with the medical task (Coupland et al., 1994). Such socio-

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1 This trajectory can be altered to accommodate different types of medical business, such as follow-up or routine problems (Byrne & Long, 1976; Robinson, 2003, 2006). Thus, researchers rely on this structural framework to the extent that participants themselves orient to it in their joint management of the progression of the medical visit (Heritage & Maynard, 2006).
relational talk can also help coordinate activity transitions when occurring simultaneously with embodied instrumental actions (e.g., positioning files, retrieving tools) at the beginning of consultation (Maynard & Hudak, 2008). Altogether, ‘prosocial’ talk is foregrounded particularly in the opening phase of doctor-patient encounters as it is the phase in which doctors and patients establish a relational basis to proceed to dealing with the medical business.

Thus, openings of medical encounters constitute a site for exploring how doctors and patients collaborate to get down to medical business and establish an interactional relationship. However, the majority of prior studies have examined US or UK primary care visits, and thus little is known about how medical openings are organized in other cultural contexts (but see Park, 2017) or in other types of consultations. This study aims to fill this gap by exploring the initial moments of dental visits in Korea, with a focus on culturally and institutionally distinctive ways in which the dentist initiates interaction with the patient.

**Interaction in Dental Consultations**

Dentistry is a unique medical setting for a number of reasons, including the fact that dentists typically have the task of performing a treatment during the consultation and patients often expect an unpleasant experience (Sondell & Söderfeldt, 1997). As of now, research on dentistry in medical discourse literature is sparse and very little is known about the organization of the opening phase of dental encounters. According to the Communication in Dental Settings Scale (CDSS), a checklist developed to assess dentists’ communication skills, dental consultations consist of opening, examination and treatment, and closing, with typical opening tasks including greeting patients,
establishing rapport, and identifying patients’ presenting concerns (Newton, 1995). Although this checklist provides an insight into professional expectations the dentists might be working under, no research has examined how these tasks are realized through specific forms of conduct.

One sociolinguistic study used recordings of dentist-patient interactions to examine how dentists in the UK exercise control over patients’ problem presentation (Coleman & Burton, 1985). The study showed that, in follow-up visits where dentists know in advance what treatment is to be administered, dentists open follow-up visits in three different ways – by immediately beginning treatment, by checking patients’ understanding about the treatment to be performed, or by checking their understanding about the treatment given in the last visit. According to Coleman and Burton (1985), these patterns may partly be due to the fact that dentists rely on their expertise, rather than patients’ opinion, to complete the treatment in a constrained time period. This study thus indicates that dentists, unlike physicians in primary care settings, may begin the consultation by immediately addressing the treatment to be rendered and preparing patients for the procedure.

In the field of CA, a small but growing body of research has investigated interactions in dental settings. Anderson (1989) examined the structural features of dental consultations by analyzing dental examination and anesthetic administration sequences; Hindmarsh and his colleagues (Hindmarsh, 2010; Hindmarsh et al., 2011) examined interactions in UK dental training, focusing on the role of the bodily conduct of dental students in demonstrating their understanding of supervisors’ comments; and Bridges et al. (2015) examined multilingual dental encounters in Hong Kong, describing the patterns
of dentist- and assistant-initiated interpretations to patients. These studies have begun to throw light on how institutional tasks are carried out in dental interaction.

Yet, in spite of the growing interest in the interaction in dentistry, many issues remain unexplored. Little is known about the opening phase of dental consultations, and, to my knowledge, there is no interactional research on dental consultations in Korea. The analysis presented in this chapter aims to fill some of these gaps in our understanding of this healthcare context.

Analysis

The analysis shows that the dentist’s first turn-at-talk is either task- or non-task-oriented. By producing a task-oriented turn right after he arrives and sits next to the patient, the dentist treats the consultation as having already been opened and moves directly to the business at hand. This is possible partly because the dentist already knows why the patient is there through the computerized records and/or the chart, and the nurse has completed some opening tasks (e.g., having the patient seated) before the dentist approaches. In contrast, by producing a non-task-oriented first turn, the dentist invites the patient to engage in the opening activity to produce a more social/personal encounter; and the initiation of the business phase is delayed.

Four different practices are used for task-oriented first turns: exam initiation, treatment plan formulation, inviting no-problem confirmation, and inviting problem elaboration. As I will show, in follow-up visits, first, the dentist may announce that he will do an examination in his initial turn of talk (e.g., “I’ll take a look”) or, second, he may formulate a plan for long-term treatment or the one to be conducted that day (e.g., “Today let’s try filling in the tooth”). Third, in both follow-up and routine visits, the
dentist may ask a question that invites patients to confirm the absence of problems (e.g., “There isn’t anything that particularly bothers you, right?”). Fourth, in new-concern visits, he may ask a question that invites patients to elaborate on their problems (e.g., “How does it hurt when you bite?”). When producing a non-task-oriented first turn, the dentist addresses off-task matters (e.g., “Today did you not go hiking?”). Through detailed analyses of each practice, I show how the first turns either bypass or expand opening components typically present in ordinary interaction, and affect the ensuing interaction by expediting or delaying the move towards the dental examination and treatment. Additionally, I explore how the resultant patterns of interaction are connected to the cultural features of Korean medical interaction and the particularities of dental settings.

Task-Oriented First Turns

Exam initiation in follow-up visits

In follow-up visits, the dentist can announce the start of the dental examination right after he arrives and sits next to the patient. By simply announcing that he will “take a look” in the very first turn of talk, the dentist shows his awareness of the problem to be examined and dealt with. Routine components of openings that usually occur in ordinary interaction (e.g., greetings or a how-are-you sequence) are absent, and the dentist moves directly to initiate the examination.

Consider Extract 1 in which the very first thing the dentist says after sitting on his chair is that he will begin the examination. Prior to the segment below, the nurse and the patient engage in a brief conversation while waiting for the dentist to come. As the dentist approaches, the nurse covers the patient’s face with a drape (line 1). The dentist then sits
down, picks up tools, and moves his chair closer to the patient (line 2). He then informs the patient that he will take a look (line 3), after which the patient opens his mouth (data not shown).

**Extract 1: D141**

1 NUR: +elkwul tephe-tuli-lkey-yo?
   face cover-HON-INT-POL
   I’ll cover your face?
   nur +((starts covering PAT’s face))

2 *{(17.0)*
   den *{(sits down, picks up tools, moves closer to PAT)}*

3 DEN: po-lkey-yo?
   look-INT-POL
   I’ll take a look?

As the dentist initiates the examination right away from the start, it is presumed that he already knows about the patient’s situation, including what needs to be examined. Indeed the patient is already arranged for examination and treatment when the dentist approaches: Not only is his dental chair inclined to a horizontal position but also his face is covered with the drape (line 1) before the dentist sits down (line 2). This pre-arrangement – which hinders the conversation between the dentist and the patient – shows that the absence of pre-examination activities (e.g., opening, problem presentation) is assumed by the nurse as well. The consultation therefore most ‘swiftly’ proceeds to the activity of dental examination.

The above extract shows that, in follow-up visits, the dentist can move directly to perform the dental examination right after he arrives and sits next to the patient. This is possible partly because the nurse has already prepared the patient for the examination activity (e.g., having the patient seated) before the dentist approaches. With the first turn
that initiates the examination, the dentist 1) communicates his understanding that the
patient is ready to begin the business at hand and 2) treats the patient’s concern as having
already been shared and established. Consequently, the dentist-patient interaction prior to
the examination is composed of only a single pair of actions: the dentist verbally
initiating the examination and the patient opening the mouth in response.

*Treatment plan formulation in follow-up visits*

In some follow-up visits, the dentist designs his first utterance with a treatment
plan formulation. The dentist either explains a long-term plan for treatment or the plan
for the day. By articulating the treatment plan as soon as he arrives and sits on the chair,
the dentist 1) treats the consultation as having already been opened and 2) reveals that the
patients’ problem had been solicited, examined, and diagnosed in previous visits and
needs no further investigation. The dentist thereby orients to facilitating the move
towards the dental examination and treatment, focusing on the ‘known’ problems.

In Extract 2, after the dentist comes into the treatment room and sits on his chair
(line 1), he formulates the plan to continue the ongoing treatment (lines 2-4).

**Extract 2: D124**

1  

((DEN comes in and sits on the chair))

2  

DEN: keysok kwanli *a- (0.2) ha-sil
continuously maintenance DM do-HON
ke-myen-un cehuy-ka
thing-if-TOP we-NOM

*If you will ah- (0.2) continue the maintenance we will*

3  

den

*((stops NUR from draping))

Δ(0.2)

pat Δ((looks at DEN))
DEN: ku phaythen-ul kac-kwu-se kunyang ha-lkey-yo, that pattern-TOP with-CONN-CONN just do-INT-POL just do {it} with that pattern, ku[nyang wuli ceki just we DM just we uhm PAT: [yey. okay Okay.

(0.5)

DEN: ceki DM uhm

(0.5)

DEN: ( )-eyse kwanli-ha-nun kes-chelem, -LOC maintenance-do-ATTR thing-like like doing the maintenance at ( ),

PAT: ney[: . okay Okay: .

DEN: [kulen phaythen-ulo ha-lkey-yo like.that pattern-with do-INT-POL {we’ll} do it with the pattern like that

PAT: =yey yey. okay okay =Okay okay.

* (.)+(0.3)

den * ((puts on mask))—>
nur + ((covers PAT’s face with drape))—>
The dentist specifies what they are going to do for the patient’s treatment in his first turn of talk, seeking the patient’s acceptance (lines 2-4). During the turn, the dentist uses his hands to stop the nurse from covering the patient’s face (line 2), which reveals his expectation that the patient will provide a verbal response to the proposed treatment plan; and the patient accepts the plan with “Okay” (line 6). The dentist goes on to explain what they will do for treatment (lines 5, 10, and 12), and the patient again consents to the treatment (line 14). After obtaining this consent, the dentist puts on the mask and the nurse covers the patient’s face with the drape (line 15), resuming their preparation for the examination and treatment.

By formulating the treatment plan in the initial turn of talk, the dentist indicates that their foremost task is to confirm the proposed plan and that other relevant activities (e.g., greetings, problem presentation) are unnecessary. This interactional pattern evidences the particular nature of dental visits – i.e., that they involve administering a treatment. Especially when a specific treatment plan is already apparent, the dentist may simply announce (and solicit acceptance of) the treatment and proceed to it, given that patients are there and ready for it. In so doing, the dentist can expedite the accomplishment of the treatment in a constrained time period (see Coleman & Burton, 1985).

While in Extract 2, the dentist formulates rather a long-term treatment plan, in Extract 3, the dentist informs the patient about what they are going to do “today” for treatment (line 2) right after he sits next to the patient (line 1).

**Extract 3: D041**

1  

((DEN sits on the chair))
After sitting and moving his chair closer to the patient, the dentist starts the conversation by explaining that they will do a filling today (line 2). Unlike the previous case, here the dentist simply informs the patient about the dental care soon to be rendered (rather than seeking acceptance of it) and prepares the patient for the procedure. He also starts putting on a mask while producing the first turn (line 2), preparing for the examination and treatment early on in the visit. Subsequently the patient sighs (line 4)
and asks about the treatment to be given (line 11); and after explaining more about the
treatment, the dentist begins his examination (data not shown). The way that the dentist
starts the interaction is thus attuned to the current stage of the ongoing care, starting from
announcing what needs to be done in the present treatment session.

By articulating the treatment plan right after he arrives and sits next to the patient,
the dentist goes straight to the business at hand and implicitly claims that their foremost
task is to administer the treatment rather than to perform other potentially relevant
opening activities (e.g., greetings). Accordingly, the ensuing conversation focuses on a
particular treatment procedure, after which the parties directly proceed to conducting the
relevant examination and treatment.

Inviting no-problem confirmation in follow-up and routine visits

In both follow-up and routine visits, the dentist often uses a question form that
invites a no-problem confirmation. This question form embodies the principle of
optimization in that it is tilted towards the ‘best case’ or ‘no problem’ state of affairs
(Boyd & Heritage, 2006). By asking this kind of question in the very first turn of talk, the
dentist goes straight to the business at hand, conveying his expectation that patients have
no ‘new’ concerns to discuss other than their ‘old’ concerns.

Extract 4 illustrates a routine check-up visit in which the patient offers a no-
problem confirmation. Before the talk is initiated, the patient is lying on a dental chair
with his eyes closed and the dentist sitting next to the patient, holding the face shield in
silence (line 1). Then, as he puts on the face shield, the dentist initiates a sequence of talk
by soliciting a no-problem confirmation from the patient (line 2).
Extract 4: D091

1  ((DEN is sitting next to PAT and holding face shield))

2 DEN: thukpyelhi pwulphyenha-n ke-n particularly uncomformtable-ATTR thing-TOP

eps-cyo.
not.exist-COMM:POL

There isn’t anything that particularly bothers you, right.

3 PAT:  *yey.
   right
   Right.²

   den *((puts on the mask))-->

4 (0.2)

5 PAT:  ºeps- eps-sup-ni-ta°
   no none-POL-DET-DECL
   ºNo- nothingº

6 (1.2)

7 DEN:  pok-i-ta pok.
luck-CP-DECL luck
Lucky you.

8 PAT:  Eh heh

9 (0.4)*(0.3)

   den -->*

10 DEN:  °Mm° (.) ham po-lkey-yo?
   DM one.time look-INT-POL
   °Mm° (.) I’ll take a look?

The dentist’s question is strongly tilted toward confirming a ‘no-problem’ state of affairs. First, the question not only contains a proposition that nothing is particularly

² Korean is an ‘agree-disagree’ language. That is, regardless of the polarity of the question, a positive particle accepts the proposed understanding in the question and a negative particle denies it (Sadock & Zwicky, 1985). The patient’s ‘yes’ particle (yey) therefore confirms the question’s proposition.
bothering, but also invites the patient to confirm the proposition by using the sentence-ending suffix -cyo which, in the Korean language, presupposes the truth of the proposition and elicits confirmation (H. S. Lee, 1999; K. Lee, 1993). Second, the use of the word “particularly” thukpyelhi qualifies the degree of discomfort that can be mentioned in response. That is, unless something is “particularly” bothering, it should not be brought up. Thus, the question design conveys the dentist’s ‘optimized’ stance toward the patient’s dental state (Boyd & Heritage, 2006).

With the question that conveys a strong commitment to the likelihood that there is nothing problematic, the dentist shows that he knows it is a most probable situation—which he may know from the chart or the computerized records. This question design thus evidences the dentist’s orientation to this being a routine visit and facilitates the move to dealing with routine matters. That is, once a no-problem confirmation is given, as expected, the dentist can rule out the need to discuss new problems and proceed directly to conducting a routine check-up. In Extract 4 above, the patient indeed gives such confirmation, and accordingly, no new dental matters are discussed: The dentist registers the response with the third-turn assessment (line 7), which prompts the patient’s brief laughter (line 8), and the examination is initiated (line 10). In sum, by asking the patient to confirm, in the initial turn of the interaction, the absence of problems, the dentist expedites the shift into the activity of dental examination.

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3 The sentence ending suffix -cyo is a combination of a committal suffix -ci and a polite suffix -yo.
A similar pattern is observed in Extract 5 in that the dentist starts the interaction by inviting no-problem confirmation (line 1), to which the patient gives confirmation by nodding (line 1) and saying “Right” (line 2).

**Extract 5: D149**

1  DEN:  thukpyelhi  *pwulphyenha-n  ∆tey-n  particularly  uncomfortable-ATTR  place-TOP
   
eps-u-si-cyo.  
not.exist-CP-HON-COMM:POL

   **There isn’t anything that particularly bothers you, right.**

   *((looks at PAT))

   △((nods))

2  PAT:  *[ney.  
   right
   [Right.

3  DEN:  *[ney.  kulemyenun  
   okay  then
   [Okay. Then

   *((looks at chart)->

4  (1.0)

5  DEN:  *cencheyczekulo  han  pen  
   overall  one time
   just  overall

   *((starts sitting down))

6  (1.0)*

   -->*

7  DEN:  (khulleyncing)-ha-nun  *cengto-lo  
   cleansing-do-ATTR  about-PT
   sort  of  doing  (cleansing)

   *((grabs mask straps))

8  (1.0)
The dentist produces the first turn while walking toward the patient who is lying on a dental chair. As the patient nods (line 1) – which confirms the candidate proposition in the prior turn that nothing is particularly bothering – the dentist acknowledges the nod with “Okay” (line 3); and this overlaps with the patient’s vocal response “Right” (line 2). This shows that the dentist treats the patient’s nodding as a sufficient confirmation. The dentist then moves on to formulate what they are going to do today for the patient’s treatment (lines 3-7). His use of the inference marker “Then” (line 3) indicates that his remark on the treatment has arisen out of the preceding interaction, i.e. the no-problem confirmation given by the patient. Hence, the dentist paves the way for the transition into the treatment activity based on the patient’s no-problem confirmation. As with Extract 4, his ‘optimized’ question formulated in the very beginning of the interaction not only gets straight to the dental business but also facilitates the transition to the dental treatment, promoting efficient progression of the consultation.

On occasion, patients may give a disconfirming response to the dentist’s request of a no-problem confirmation. In Extract 6 from a follow-up visit, the dentist similarly seeks to confirm the patient’s no-problem state in his first turn while he sits on his chair next to the patient (line 2). When the patient does not immediately respond (see the gap in line 3), the dentist modifies his question to invite a problem report (line 4).

**Extract 6: D053**

```
1  ((DEN approaches PAT))

2  DEN:  *thukpyelhi  pwul- pwulphyenha-n tey-n  
      particularly uncomfortable-ATTR    place-TOP  
      eps-usi-cyo?  
      not.exist-HON-COMM:POL

      There isn’t anything that particularly bothers
```
you, right?

$\text{DEN}$ *(starts sitting on chair)*

3 (1.1)

4 $\text{DEN}$: iss-usey-yo,
extist-HON-POL
{Or} is there,

5 (0.2)

6 $\text{PAT}$: manh-e
many-IE
A lot

7 $\text{DEN}$: eti-ka ceyil manh-usey-yo
Where-NOM most many-HON-POL
In which area are there the most {problems}

8 (0.4)

9 $\text{PAT}$: cencheey-ka ta °( )°
whole-NOM all
Everywhere is all °( )°

10 $\text{DEN}$: Heh huh huh .hh hh .h h .h h .h hh .hh ((laughs))

In modifying his question, the dentist reverses the preference of the question so as to anticipate the presence of problems (line 4) (Heritage, 1984a; Sacks, 1987). In response, the patient claims to have “a lot” of problems (line 6), producing a non-type-conforming answer (Raymond, 2003), without immediately specifying what the problems are. In so doing, the patient indicates the inappropriateness of the dentist’s prior questions. Accordingly, the dentist pursues a more specific report (line 7), which the patient resists, claiming instead that the problems are “everywhere” (line 9). Altogether, the patient resists the dentist’s optimized stance by insisting on the seriousness of his problems.

Subsequently, the dentist produces laughter in order to overcome and ‘laugh off’ the patient’s resistance (Zayts & Schnurr, 2011). The dentist then identifies what the
current problems are and delivers a long-term treatment plan (data not shown), displaying his understanding of the patient’s concerns – which he had failed to do in the phrasing of the opening question. In sum, the patient’s refusal to provide a ‘no-problem’ answer calls for additional interactional work to identify the dental problems and to deal with the inappropriateness of the question design.

Overall, in follow-up or routine checkup visits, the dentist may invite patients to confirm the absence of problems in the very first spoken turn. These first turns communicate the dentist’s understanding that patients are ready to begin the business at hand and have nothing ‘new’ to discuss other than their ongoing or routine concerns. These turns can thereby expedite the progression of the visit because, once patients confirm, the dentist can directly move to examination and treatment of the patients’ ‘old’ concerns. In cases when patients indicate the presence of problems, additional interactional work may be needed to manage their resistance to the optimized stance conveyed by the question design.

Inviting problem elaboration in new-concern visits

In new-concern visits, the dentist is found to design the first turn of talk by asking patients to elaborate on their problems. Importantly, the dentist solicits specific symptom-related information at the very beginning, revealing his knowledge of the patients’ chief complaints (that had been disclosed to the nurse beforehand). The dentist thereby proposes the relevance of medical information gathering and the dentist-patient interaction starts directly with the activity of history taking.

Extract 7 shows the first moments of a new-concern visit. After sitting down in his chair, the dentist puts on his mask in silence, while looking at the screen that shows
an x-ray of the patient’s teeth (line 1). This embodied behavior shows that the dentist has already begun investigating the patient’s problem through the x-ray without saying anything. He then initiates a sequence of talk by asking the patient how it hurts when she bites (line 2).

Extract 7: D105

1 ((DEN sits on chair, and then puts on mask while looking at x-ray))

2 DEN: ssip-ul ttaay etten sik-ulo aphyu-se-yo? bite-ATTR time how way-PT hurt-HON-POL
   How does it hurt when you bite?

3 (1.5)

4 PAT: ku ikhey ttakttak-han ke-l mos that like.this hard-ATTR thing-TOP cannot
   ssip-keyss-eyo. bite-DR-POL

   It’s like I can’t bite hard things.

5 (1.1)

6 DEN: (ko-) (0.5) ku:: (. ) ttakttak-haci anh-un DM DM hard-COMM not-ATTR
   pwupwun-un ettay-yo?
   part-TOP how-POL

   (Uh-) (0.5) Uhm:: (. ) how about the bits that are not hard?

As the dentist invites the patient to elaborate on her symptoms in the very first speaking turn of the encounter, he treats the patient’s chief concern as having already been established, and the conversation starts with the activity of history taking. By immediately asking about concrete symptoms (i.e., how it hurts when biting food), the dentist sets the specific topical agenda for the patient’s response, and accordingly, in the
following turn, the patient focuses on describing her difficulty in chewing food (line 4). In this way, the dentist’s question constrains the content and extent of the patient’s response.

The ‘rapid’ progress toward history taking illustrated by this segment has also been observed in acute primary care visits in Korea. According to Y. Park (2017), Korean physicians use a “Where does it hurt”-type question in acute visits to constrain patients’ response to a single unit, promoting a ‘quick’ transition into history taking. Note that, in the segment above, the patient’s problem presentation is bypassed altogether. The dentist’s question presumes that he knows the patient has biting problems and is oriented towards gathering more information for diagnosis. This ‘rapid’ move towards history taking can thus be connected to the cultural features of Korean medical communication. Moreover, it may also be fitted to the uniqueness of dental settings. When the dentist comes and sits, the x-ray is visible on the screen, and thus, the dentist can take a look at it and immediately progress to investigate the problem as he begins the consultation.

In Extract 8, the dentist uses a similar question in the first turn by asking the patient how it hurt (line 1). The use of the word “there” shows that the dentist already knows where the pain exists.

**Extract 8: D067**

1 DEN:  keki-ka etten sik-ulo aphi-sye-ss-e-yo?
          there-NOM how way-PT hurt-HON-PAST-DC (or IE)-POL
          How did it hurt there?

2  (1.0)

3 PAT:  eyeki-yo?
          here-POL
          Here?

          pat  Δ((touches his face))
By inviting the patient to elaborate on how it hurt “there” in the very first turn of the encounter, the dentist not only shows his awareness of where the pain exists but also launches the discussion of the problem immediately from the start. Similar to Extract 7, the conversation starts with the activity of history taking, without giving the patient an opportunity to fully explain his problems in his own words. In this way, the participants effectively proceed to dealing with the single major problem which was originally reported to the nurse by the patient.

Subsequently, the patient checks which area the dentist refers to by asking “Here?” (line 3), touching the candidate place with his hand, before responding to the doctor’s question. This understanding check implies that the word “there” in the previous turn is not clear enough for the patient to establish a mutual orientation toward the placement being talked about. Especially because the dentist uses the deictic pronoun in the very first turn of the conversation, the patient may have insufficient resources to identify the place being referred to. After the dentist confirms the area (line 4), the patient responds to the initial history-taking question (line 6).
In new-concern visits, the dentist may ask patients about their specific problem in his first turn-at-talk, treating the visit as having already been opened and displaying an awareness of the patients’ concerns. That is, the dentist takes the patients’ history from the start, relying on the information that had been previously disclosed to the nurse and what is visible through the x-ray. The patients elaborate on their problems in response, conforming to the topical agenda set by the history-taking question.

Non-Task-Oriented First Turns

So far we have seen different practices for initiating task activities from the very start of the dentist-patient interaction. Taken together, these practices evidence the dentist’s orientation to accomplishing dental tasks as the first order of business after approaching the patient, with no off-task/interpersonal talk. In this section, I present an alternative interactional trajectory also found in my data – with the dentist engaging in the opening activity with off-task/interpersonal talk.

By using off-task talk in his initial turn, the dentist displays an orientation to relational goals (Coupland, 2000). That is, with a non-task-oriented first turn, the dentist chooses to produce a more social/personal opening instead of a transactional/task-focused interaction. Notably, in the data under analysis, off-task talk used in the first turn always shows that the dentist and the patients know each other well. This indicates that the dentist may initiate the opening activity to enact his familiar relationship with patients, despite the general tendency to facilitate a move towards the dental examination and treatment. While engaging in off-task conversation, the dentist usually readies himself with objects he needs for the upcoming examination and treatment, indicating that the
ongoing ‘chat’ will shortly be over and projecting a transition into the business phase of
the encounter.

In Extract 9, the dentist opens the interaction with the patient by talking about the
patient’s hobby of going hiking, inviting the patient to engage in the opening interaction
(lines 2-3). After sitting on his chair (line 1), the dentist acknowledges, in his first turn of
the encounter, that the patient did not go hiking that day, which reveals his knowledge
that the patient normally goes hiking at the time of the appointment. This tells us that the
two parties know each other quite well.

**Extract 9: D096**

1     ((DEN sits on chair))

2 DEN: o(h)nul(h)-un (0.2) san-ey an ka-
today-TOP mountain-LOC not go
To(h)da(h)y (0.2) did you not go-

3 an *tanye-o-sye-ss-eyo?
not go-come-HON-PAST-POL
not go hiking?

den *((puts on mask))-->

4 PAT: ey- (.) onul ka-llako ha-taka
DM today go-PURP do-TRANS
Ey- (.) today I was about to go but

5 (0.4)

6 PAT: yeki ka-ss-taka nacwungey ka-llakwu.
here go-PAST-TAKA later go-PURP
came here first and will go {hiking} later.

7 DEN: a a::
oh oh
Oh oh::

The dentist’s first turn is distinctive in that it is designed for this particular patient
by conveying an expectation of the patient going hiking, demonstrating their close
relationship. It is thus different from a typical ‘how are you’-type question that commonly occurs in opening exchanges in the US/UK context (e.g., Coupland et al., 1992). Importantly, unlike the cases in which the dentist immediately advances the business of the visit, here, the casual, off-task conversation takes place first to enact the parties’ familiarity. This indicates that, although provider-patient interaction in Korea tends to be impersonal and is oriented to ‘efficient’ progression of the consultation (Park, 2013, 2017), when the visit involves a familiar patient, providers may invite the patient to engage in the opening sequence to produce a more personalized and informal interaction.

Note that the dentist is bodily oriented to work-related activities as he starts to put on a mask when articulating the first turn (line 2), preparing for the upcoming dental examination. He is thus ‘multiply involved’ in the ongoing ‘chat’ and exam preparation (Toerien & Kitzinger, 2007). Nonetheless, the launch of dental activities is merely projected at this point, and the delay of on-task talk in favor of off-task talk gives precedence to the dentist’s relational goals over institutional ones.

In Extract 10, the nurse covers the patient’s face with a drape while the dentist sits on his chair (line 1). The dentist then initiates the conversation by humorously calling the patient’s name (line 2).

**Extract 10: D123**

1. \((\text{NUR covers PAT’s face and DEN sits on chair})\)

2. DEN:  *wuli miyeng-i akassi-ka
   our  NAME  lady-NOM
   Our dear Miyeong
   
   den  *((starts putting on mask))

3. \((0.4)\)

4. DEN:  a  cinanpen-ey  emma ollao-syess-taka (.) ( )-
oh last.time-TEMP mom come-PAST-TRANS
Oh last time your mom came and (.) (     )-

5 *(0.2)
den *((takes off glasses))

6 DEN: yeki ta- ikey kkuthna-ko o-sye-kacko
here all this close-CONN come-HON-so
here all- she came after we closed so

7 mos hay-ss-nuntey
cannot do-PAST-CIRCUM
{we} couldn’t get to do {the consultation} and

8 PAT: *Heh hah ((laughter))
den *((picks up face shield))

9 *(0.3)

Given that the use of overt recipient-reference is rare in Korean (Oh, 2007), the
dentist’s overt reference to the patient’s name Miyeong, prefaced by “our” wuli and
followed by “lady” akassi, can be understood as showing affiliation and friendliness. The
dentist thus personalizes the opening interaction, enacting his familiarity with the patient.
He then recalls that the patient’s mother had come to the clinic (line 4), using a turn-initial
Korean particle ah (equivalent to English “oh”) that indicates ‘just now’
remembrance of the past event (Bolden, 2006; Jefferson, 1978). This demonstrates the
dentist’s acquaintance with the patient’s mother as well, again showing their familiar
relationship. Hence, the dentist initiates the opening sequence to produce a more
personalized/relational encounter, postponing the move to dealing with the dental tasks at
hand.

Note again that the dentist’s embodied actions – putting on a mask (line 2), taking
off his glasses (line 5), and picking up a face shield (line 8) – project a transition into
task-focused activities, indicating that the off-task talk will shortly be over. Nonetheless,
by choosing to engage in off-task conversation before launching dental tasks, the dentist prioritizes producing a familiar and informal opening over initiating medical business.

To summarize, with a non-task-oriented first turn, the dentist invites patients to extend the opening activity to construct a relatively personalized interaction, postponing the launch of the business phase of the visit. What is particular about these first turns in the present data is that they always show the dentist’s acquaintance with the patients. The dentist thereby prioritizes enacting a friendly relationship with the patients over dealing with dental problems to produce a more social/personal opening. This may imply that, despite the general orientation to efficient progression of medical visits in Korea, enacting and renewing providers’ and patients’ familiar relationship can supersede task accomplishment in opening encounters.

**Summary and Discussion**

In this chapter, I have examined the design of the dentist’s first turn-at-talk in Korean dental consultations. The analysis of the data showed that the dentist uses either a task-oriented or a non-task-oriented first turn. By producing a task-oriented turn right after approaching the patient, the dentist goes straight to the business at hand, treating the consultation as having already been opened and constructing the interaction as transactional/task-focused. Furthermore, these first turns are designed to facilitate the move towards the dental examination and treatment, with the deployment of the dentist’s prior knowledge of patients’ chief concerns: The dentist immediately initiates dental examination (Extract 1); formulates a treatment plan based on his prior knowledge of the patient’s case (Extracts 2 and 3); briefly re-checks that patients have no new concerns other than their follow-up or routine problems (Extracts 4, 5, and 6); and invites
elaboration on the specific concerns previously reported to the nurse (Extracts 7 and 8). The dentist thereby focuses on ‘known’ problems and starts from the most immediate task based on what he knows about the patients’ dental history. In contrast, with a non-task-oriented first turn, the dentist invites patients to engage in the opening interaction to produce a more personalized encounter (Extracts 9 and 10). Accordingly, unlike the other cases, the occurrence of medical/on-task talk is deferred.

The analysis of the task-related first turns shows the dentist’s orientation to the ‘rapid’ progress towards the dental examination and treatment, which can be culturally and situationally specific. First, according to Y. Park (2017), the brevity of the openings of Korean medical visits is related to the Korean healthcare system, which prompts doctors to have quick patient turn-over, and to a cultural expectation for a ‘rapid’ accomplishment of tasks in Korean institutional encounters (see also Bailey, 2000; Y. Park, 2013). Second, such efficient progression of the visit can be fitted to the unique body arrangements involved in dental settings. Patients are seated in a dental chair reclined to a horizontal position when the dentist arrives to open the visit, and thus the interaction with the dentist prior to the activities of examination and treatment might be predicted to be fleeting. Patients may turn their heads and gaze at the dentist to engage in conversation, but their heads will need to be returned to a forward-facing position for the examination, making an extended conversation difficult (cf. Schegloff, 1998a). Also, given that the nurses are on standby to cover patients’ face with a drape, patients’ engagement in interaction with the dentist can be temporary and secondary to their projected involvement in examination and treatment.
It is significant to note that there are cases in which the dentist uses off-task talk in the first turn to produce a more personalized and informal opening. These cases depart from the patterns described above in that the opening sequence is expanded, which results in the delay of on-task talk. One important feature of the non-task-oriented first turns is that, in my data, they always reveal close relationships between dentist and patient. The overriding goal of the dentist in the use of off-task talk is then to enact and renew his familiar relationship with regular patients. It can therefore be suggested that, despite participants’ general orientation to the ‘quick’ move towards next phases, enacting a familiar relationship between dentist and patient can supersede task accomplishment in opening dental visits. Although further investigation is needed to see if the same pattern holds true in other clinical contexts in Korea, this study offers preliminary evidence that Korean medical professionals may prioritize relational concerns over instrumental ones when initiating interaction with familiar patients.

The findings presented here advance our understanding of culturally-specific features of Korean medical communication and unique aspects of interaction in dental settings. Participants’ orientations to the expeditious progress towards dental examination and treatment have been connected to the distinctive features of Korean culture, on the one hand, and to unique aspects of dental care settings, on the other. Moreover, it was shown that enacting a familiar relationship between dentist and patient can take precedence over discussing dental issues, which further illuminates culture-specific aspects of Korean medical interaction. Finally, this study advances our understanding of interactional openings by showing how they can be situationally modified to accomplish tasks and goals in a particular cultural/institutional setting (cf. Wakin and Zimmerman,
My analysis indicates that it is through such modifications of opening practices that participants work out whether they will immediately get down to business or engage in interpersonal/relational work first. Further research is needed to compare the findings presented here to other forms of openings in different cultural/institutional contexts.
Chapter 5: Achieving Activity Transitions in Dentist-Nurse-Patient Encounters

Introduction

Dental consultations, unlike many other types of medical consultations, involve both inter-professional collaboration and provider-patient interaction. Dentists and dental nurses routinely collaborate to prepare for and carry out dental procedures while they interact with patients. This creates complexities for the process of coordinating actions as participants attend to multiple parallel activities (e.g., setting up for dental examination and discussing dental problems). This chapter examines how dentists, nurses, and patients collaboratively accomplish a transition into the dental examination. Research in conversation analysis has shown that interactants monitor and analyze each other’s embodied conduct and handling of objects to anticipate the action or activity that is about to occur (e.g., Greatbatch et al., 1995; Heath et al., 2018; LeBaron & Streek, 2000; Mikkola & Lehtinen, 2014; Robinson & Stivers, 2001). This chapter extends this prior research by showing how dentists, nurses, and patients use talk, embodiment, and material objects to make relevant and timely contributions to the process of transitioning into dental examination. The findings contribute to prior literature on activity transitions in clinical encounters, the coordination of collaborative work among healthcare professionals, and the organization of triadic, dentist-nurse-patient interaction.

In dental consultations, several distinct actions are regularly implemented before the examination begins. First, dentists put on a mask and a face shield for hygienic reasons, and prepare a dental mirror which helps them view inside patients’ mouth; second, particularly in Korean contexts, nurses routinely cover patients’ face with a drape, which is there to protect patients’ facial area from splashes of fluids during
examination and treatment; third, patients open their mouth for inspection. These actions hinder proper interaction between dentist and patient to varying degrees. For instance, patients become unable to see the dentist once their face is covered, and thus the precise timing at which nurses cover patients’ face is critical. Placing a drape too early would interrupt the ongoing dentist-patient interaction and too late would delay the transition into examination. Also, for patients, opening their mouth too early for inspection would impede further progression of conversation and too late would delay the shift into examination. The analysis presented in this chapter will show how participants work to implement each of these preparatory actions at the precise time of need so as to accomplish activity transitions smoothly and in a timely manner.

To transition into the dental examination, the three different parties – dentist, nurse, and patient – establish a shared understanding of the point at which each step of exam preparation can be made. Previous studies have examined activity transitions in dyadic, physician-patient encounters (e.g., Heath, 1986; Robinson, 2001; Robinson & Stivers, 2001); however, they do not explain how activity transitions are negotiated in triadic, dentist-nurse-patient encounters. Furthermore, studies on inter-professional collaboration in clinical settings have focused on such procedures as surgery (e.g., Heath et al., 2018; Mondada, 2014b) or anesthesia (e.g., Hindmarsh & Pilnick, 2002) in which patients are rarely able to talk. In this chapter, I will describe the unfolding of the triadic dental encounter to show how dentists, nurses, and patients coordinate their contributions to the transition process in situ.

The chapter is structured as follows: I begin by reviewing prior work on activity transitions in physician-patient encounters and on inter-professional collaboration in
surgery and anesthesia. This literature review will involve discussions of the interactional practices associated with projecting and anticipating next actions in interactants’ joint management of tasks and activities in clinical settings. I then examine two broad sets of practices for implementing activity transitions. First, participants shift into dental examination tacitly, i.e. without referring to the examination, by relying on each other’s embodied conduct and use of objects that project the transition. Second, participants use talk to implement the shift into dental examination, i.e. they explicitly refer to the examination. My analysis will show that talk is deployed when the other parties’ cooperation with the transition is not forthcoming. Through the detailed analysis of these patterns, I show that dentists, nurses, and patients orient to local contingencies and the routine order of the transition steps to collaboratively make the transition into the dental examination.

Background

Activity Transitions in Physician-Patient Encounters

Prior studies have revealed that there are standard sets and orders of activities that constitute medical consultations (Drew & Heritage, 1992). For instance, physician-patient encounters that involve the presentation of new concerns are typically composed of (a) opening, (b) history taking, (c) physical examination, (d) diagnosis, (e) treatment, and (f) closing (Byrne & Long, 1976; Waitzkin, 1991). Previous CA research on one-on-one primary care visits has revealed some of the ways in which doctors and patients negotiate transitions between these activities, identifying a range of communicative resources deployed for activity transitions (e.g., Heath, 1986; Modaff, 2003; Robinson, 1998, 2001; Robinson & Heritage, 2005; Robinson & Stivers, 2001). Using video recordings of actual
medical encounters, these studies have shown how physicians and patients interactionally accomplish activity transitions as they jointly manage the progression of the medical visit.

Some activity boundaries within medical encounters are negotiated primarily through bodily conduct. During openings, for instance, patients wait until doctors shift their gaze and body away from medical charts, and toward patients, to start discussing medical concerns (Heath, 1986; Robinson, 1998). During the transition to closings, doctors and patients turn their gaze and body away from each other once their last topics – future arrangements and final concerns – are resolved (Robinson, 2001). Such bodily action serves as visual evidence for the completion of the business of the visit and the relevance of closing (Robinson, 2001). Doctors’ and patients’ embodied actions thus help them construct a shared understanding of what has happened and what is to come next, serving as an important means for negotiating a transition into a new activity.

Talk is also an integral part of activity transitions. During the problem presentation phase, doctors and patients orient to the description of current symptoms (i.e., symptoms that are experienced here-and-now) as the completion of problem presentation and the point of transition into history-taking (Robinson & Heritage, 2005). This is evidenced by the fact that physicians frequently produce a history-taking question upon patients’ description of current symptoms and that patients explicitly indicate their turn completion when this transition point is bypassed (Robinson & Heritage, 2005). In addition, the acknowledgement tokens “okay” and “alright” can be used to display

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4 In British consultations, patients enter the doctor’s office where doctors already reside, which is the opposite from the arrangement in the US.
speakers’ readiness to close a prior sequence of action and move toward new matters (Beach, 1995).

Importantly, talk and bodily conduct are not separate alternatives but different types of resources that can be used together to accomplish activity transitions. According to Robinson and Stivers (2001), patients can rely on both physicians’ embodied actions and verbal explanations to understand that the transition into physical examination is in progress. Because physicians ordinarily use their body to prepare for examinations (e.g., retrieving tools, approaching patients), their bodily actions, along with the handling of objects, become communicative resources that project a shift into examination. When patients fail to collaborate with these transition-relevant bodily behaviors, physicians explicitly state that they will begin the examination (e.g., “Let me examine you”) to prompt patients’ cooperation. In this way, multiple modalities can be used together to accomplish activity transitions (Robinson & Stivers, 2001).

In sum, previous studies have shown that doctors and patients negotiate activity boundaries in a medical visit by using each other’s talk, embodied conduct, and use of objects as resources for foreshadowing what is to come next. In particular, attention has been drawn to the diversity of resources mobilized to establish a shared understanding of the situation and jointly move the encounter forward. In other words, the importance of embodiment and materiality, in addition to talk, has been highlighted as they provide crucial resources for making sense of interaction in clinical settings.

Inter-Professional Collaboration in Clinical Settings

Recent studies of interaction in health care have explored settings beyond the dyadic doctor-patient encounter, including those between medical professionals
themselves (Pilnick et al., 2009). Of particular relevance to the current study are those on anesthesia and surgery, where inter-professional teamwork is essential for the successful accomplishment of medical procedures. Drawing on ethnomethodology and CA, studies in this area have examined practitioners’ talk, bodily conduct, and their use of objects and artifacts, revealing interactional practices for the collaborative production of anesthetic and surgical procedures (e.g., Bezemer et al., 2011; Hindmarsh & Pilnick, 2002, 2007; Koschmann, 2012; Mondada, 2014; Pilnick & Hindmarsh, 1999).

Hindmarsh and Pilnick (2002, 2007) showed that anesthetic teamwork relies on the team members’ ability to expertly ‘read’ each other’s actions to project and anticipate what comes next. Notably, when patients are awake, practitioners design their conduct as sensitive to both the patient’s presence and their colleagues’ ongoing work. For instance, upon seeing their colleagues preparing an oxygen mask, anesthetists can explain to patients that oxygen will be given for breathing; and based on anesthetists’ ongoing instruction about how patients will feel during anesthetic injection, assistants can provide relevant support moment-by-moment. Hence, it is practitioners’ ability to discern the ongoing trajectory of the procedure and properly act upon each other’s contributions that enable the concerted production of anesthetic work (Hindmarsh & Pilnick, 2002, 2007).

Research on interactions in surgical settings has mostly focused on how objects and instruments are exchanged between personnel as it is the central collaborative task during surgery. Studies have examined, for instance, the use of instructions, directives,

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5 Relatedly, CA studies on interpreter-mediated consultations have examined how medical professionals and interpreters collaborate during the consultation. Pasquandrea (2011) showed that doctors and interpreters rely on multimodal resources (e.g., speech, gaze, gesture, and object manipulation) to manage multiple actions at the same time. Bolden (2018) showed that interpreters continuously monitor and analyze the ongoing activity to promote its efficient progress and minimize disruptions.
and requests that enable the passing of tools (e.g., Bezemer et al., 2011; Koschmann, 2012; Koschmann et al., 2011; Mondada, 2014), the impacts of the layout of objects and participants on the speed of object transfer (e.g., Korkiakangas et al., 2014; Sanchez Svensson et al., 2007), and the precise ways in which implements are grasped, manipulated, passed, and received (e.g., Heath et al., 2018). These studies have shown that the seemingly simple task of instrument exchange rests upon staff members’ ability to anticipate what is needed and when, given the co-participants’ concurrent actions and activities. Although nurses and assistants are able to provide the correct equipment at the right moment, surgeons may use explicit instructions, directives, and requests to prevent the ‘late’ passing of tools or to identify the specific type of instruments required (e.g., Bezemer et al., 2011; Mondada, 2014). All in all, it is through practitioners’ finely tuned coordination of spoken, bodily, and material conduct, and their ability to assess the current status of the ongoing procedure, that surgical work can be accomplished.

Studies in anesthesia and surgery have shown that the key for collaborative work is staff members’ sensitivity to their colleagues’ ongoing actions and their ability to provide what is needed at an appropriate moment. Dental consultations, however, can involve distinctive ways of coordinating work. Dental professionals often collaborate on tasks (e.g., setting up for dental treatment) while patients are actively taking part in the ongoing interaction (e.g., discussing dental problems). The timing at which relevant equipment is set up can affect and be affected by the ongoing dentist-patient interaction. Furthermore, dental patients are aware of how the encounter generally proceeds through their repeated experience. Patients, for instance, know that they should open their mouth for inspection after their face is covered with a drape, which enables them to make their
own contributions to coordinate activities. This chapter aims to advance our understanding of how dentists, nurses, and patients routinely coordinate their actions to shift into the activity of dental examination.

**Analysis**

As described previously, during dental consultations, participants regularly carry out preparatory actions for conducting a dental examination: The dentist puts on a mask and a face shield and prepares a dental mirror, the nurses cover patients’ face with a drape, and patients open their mouth for inspection (Figure 3). In this section, I examine how participants implement each of these actions in a timely and appropriate manner to collaboratively accomplish the transition into the dental examination. The analysis begins by focusing on transitions made tacitly via embodied and material resources. I then examine transitions made with the help of verbal references to the examination, which include the nurse’s announcement of drape placement (e.g., “I’ll cover your face”), and the dentist’s announcements of exam initiation (e.g., “I’ll take a look”) produced before and after drape placement. These announcements are produced when the other parties’ cooperation is not immediately undertaken. That is, participants use talk to prevent potential delays in accomplishing activity transitions.

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6 Nurses usually lower patients’ dental chair to a reclining position, and fold the drape in half and put it on patients’ chest before the consultation begins. The drape is then unfolded and placed onto patients’ face when the dental examination begins.
Transitions Accomplished Tacitly

One way participants accomplish the transition into dental examination is by monitoring each other’s bodily conduct and use of objects, along with the ongoing talk, without explicitly referring to the activity transition. Before shifting to the examination, the dentist and the patient generally discuss dental problems and/or treatment plans. In my data, the dentist is routinely engaged in ‘multiactivity’ (Haddington et al., 2014) as he gets ready for the examination (e.g., putting on a mask) while talking to the patient at the same time. The nurse monitors the dentist’s embodied readiness as well as the ongoing discussion of dental problems to assess an appropriate moment to cover the patient’s face. The nurses in my data routinely adjust their manual action of handling the drape by, for instance, accelerating, retarding, suspending, or retracting their action so as to coordinate it with the conduct of dentist and patient (Lerner & Raymond, 2017). Notably, the nurses start to unfold and place the drape before the dentist is completely ready for the examination and/or the dentist-patient conversation is completely over. In this way, they cover patients’ face ‘on time’, i.e. by the time when the dentist is fully ready to start the examination. In addition, after their face is covered, patients also try to open their mouth
at the ‘right’ moment by relying on their sensory access to the environment, such as the
sound of the dentist coming closer or the touch of the dentist’s hands on their face.
Consequently, the transition is unproblematically achieved without verbally referring to
the examination.

Extract 11 illustrates this transition accomplished in a tacit manner. This
consultation is opened with a conversation about the patient’s granddaughter visiting her
house (data not shown). The dentist shifts to task-oriented talk as he starts listing three
treatment options (line 1) while gazing at the screen that shows an x-ray of the patient’s
teeth.

Extract 11: D111

1 DEN: onul (0.2) ce imphullanthu-lul ceyke-lul ha-lke-nya,
today that implant-ACC remove-ACC do-INT-INTERR
Today (0.2) {it’s} whether to remove that implant

2 DEN: .hhh (0.3) animyen
or
.hhh (0.3) or

3 Δ(1.0)

pat Δ{(opens mouth)}-->  

4 DEN: ismom celkay-lul han-pen te ha-lke-nya anymyen
gum cut-ACC one-time more do-INT-INTERR or
to cut the gum one more time or

5 DEN: hayntulling cal ha-si-nun ke-l
handling well do-HON-ATTR thing-ACC

*han-pen te cikhyepo-lke-nya icey
one-time more see-INT-INTERR now

wait and see again while you are handling {self-care}

den *{((grabs mask straps; Figure 4))}
Figure 4: The dentist holds the mask straps to tie

6   
(0.8)

7 DEN:  olunccok wi-ev kkey.
   right.side upper-LOC thing
   The thing on the upper right side.

8   (0.2)*(0.2)Δ

den    *((ties mask straps))-->
pat   --><Δ

9 PAT:  olunccok wi-yo,
   right.side upper-POL
   Upper right side,

10 DEN:  ney. wi-ev (kke)
   yes upper-LOC thing
   Yes. The upper (thing)

11   (1.1)*

den    -->*

12 PAT:  u::[:gh(hhh) ((sigh))

13 DEN:   [calu.lke-nya,
         will.cut-INTERR
         Whether to cut {it},

14   (0.6)

15 DEN:  han-pen te calu-l*ke-nya animyenu
   one-time more cut-INT-INTERR or
   Whether to cut {it} one more time or

den         *((takes off glasses))

16   (0.8)

17 DEN:  cikhye-1*ke-nya, animyenu ayey
see-INT-INTERR or just wait and see, or just
den *((picks up face shield))

18 DEN: ceyke-ha-lke-nya [°(    )°]
remove-do-INT-INTERR remove {it} °(    )°

19 PAT: [onul kuke *kyelceng-ha-lke-eyyo, today that decide-do-INT-POL
Are we going to decide that today,
den *((puts on face shield))

20 DEN: ani-yo *kuleh-ci anh-ayo onul-to po-lke-eyyo. not-POL like.that-COMM not-POL today-also see-INT-POL
No we are not we will see today too.
den *((moves hands to pick up dental mirror))

21 DEN: po+-ko?
see-CONN
See and

nur +((moves hands to turn on light))

22 (0.5)+(0.2)

nur +((turns on light; Figure 5))

Figure 5: The nurse turns on the exam light

23 DEN: *(hyensangyuci ha-l ke-n) hay+-po-ko maintenance do-ATTR thing-TOP do-try-CONN
try (maintenance if needed) and
den *((moves closer to PAT))
nur *((moves closer to PAT)) +((covers face))-->
When the dentist articulates the last treatment option, he grabs the mask straps to tie (line 5; Figure 4), which projects a transition from talking about the treatment to performing the examination and the treatment. Yet, the nurse does not move her hands to prepare for the examination, which may be due to two factors. First, the patient has been opening her mouth while listening to the treatment options (lines 3-8; Figure 4), displaying her fear or anxiety of the treatment being discussed; and thus it may be inappropriate to cover her face when she is displaying recipiency to ongoing talk. Second, the patient asks a question to confirm the location of the problematic area (line 9), which projects further talk from the dentist. The nurse, therefore, does not unfold the drape based on the indication of further interaction between the dentist and the patient.

The dentist continues prepping for the examination while the conversation goes on. He ties the mask straps (lines 8-11), while the question-answer sequence is produced (lines 9-10); takes off his glasses (line 15) and picks up the face shield (line 17), while
reformulating the treatment options (lines 13-18); puts on the face shield when the patient asks about the plan for “today” (line 19); and then picks up the dental mirror while answering the question (line 20). In this way, the dentist pursues two lines of business at the same time – i.e., getting ready for the examination and treatment, and talking about the treatment plan.

Notably, it is after the dentist moves his hands to pick up the dental mirror (line 20) that the nurse moves her hands to turn on the exam light (lines 21-22; Figure 5), and after the dentist moves closer to the patient (line 23) that the nurse unfolds the drape to cover the patient’s face (line 23; Figure 6). In terms of the ongoing sequence of talk, the nurse might expect that it is coming to an end because the dentist has finished reformulating the treatment plans (lines 13-18) and has given a disconfirming response (with a ‘no’ token ani) to the patient’s question, followed by an elaboration regarding the plan for “today” (line 20). Nonetheless, it is mainly by virtue of the dentist’s embodied actions that the nurse conclusively determines when to carry out the relevant preparation. This is evidenced by the fact that the nurse undertakes the preparation upon seeing the dentist’s movements of picking up the dental mirror and approaching closer to the patient.

Note also that the patient opens her mouth (line 24) shortly after her face is covered with the drape by the nurse, without relying on any verbal request or instruction. This is possible because the patient has seen the nurse turning on the light (line 22) and the dentist approaching closer (line 23) right before her face is covered (lines 23-24). The patient can, therefore, expect that the examination will soon begin and act accordingly by opening her mouth as soon as her face is covered. Consequently, the dental examination
is unproblematically launched without the use of verbal references to the examination. That is, participants tacitly shift into the dental examination by relying on each other’s embodied conduct and handling of objects that project the activity transition.

To summarize, the transition to the dental examination can be accomplished without verbalizing the activity shift. This is possible because participants can provide relevant actions at the ‘right’ moment by closely monitoring each other’s ongoing talk, embodied conduct, and handling of objects. As the dentist can see the nurse starting to unfold the drape and the patient opening the mouth, he can go on without explicitly notifying them of the start of the examination.

Transitions Accomplished through Talk

While the transition into the dental examination can be made without referring to the examination, participants can still employ talk to explicitly inform others of what they are will do for the activity transition. In my data, for instance, the nurses announce that they will cover patients’ face or the dentist announces that he will begin the examination. Importantly, the analysis shows that dental professionals produce their announcement when the other parties’ cooperation is not immediately forthcoming. That is, talk is used in the face of others’ lack of cooperation in the transition process (Robinson & Stivers, 2001). The design of the announcements is notable because dental professionals in my data articulate what they will do (e.g., “I’ll cover your face”) instead of what others should do. In so doing, they demonstrably rely on their co-participants’ local knowledge and ability to provide an appropriate action for the transition. In addition, by making the announcement at a particular moment in the transition process, professionals work to secure others’ cooperation ‘on time’.
Nurse’s announcement of drape placement

The nurses in my data recurrently announce their action of covering patients’ face with a drape. Because face-covering requires patients’ readiness and compliance, the nurses verbally describe their physical action of drape placement to notify patients of the forthcoming action and secure their cooperation with it. At the same time, with this announcement, the nurses alert the dentist that the examination setup is being carried out and that the patient will soon be ready for the examination.

In Extract 12, for instance, the nurse states that she will cover the patient’s face during her drape placement. Prior to this segment, the dentist formulates a long-term treatment plan, after which the patient asks about the plan for “today” (data not shown). The dentist explains that they will perform a dental cleaning and elaborates on further plans (lines 1-5). As soon as the dentist moves his hands to pick up the chart (line 3), the nurse swiftly moves her hands to take hold of the drape (line 3), orienting to the dentist’s hand movement as getting ready for the dental examination. Yet, the nurse remains holding the drape, momentarily suspending her action of unfolding it (Lerner & Raymond, 2017), because it turns out that the dentist has picked up the chart to show it to the patient (line 3) and to continue their discussion of the treatment plan.

Extract 12: D130

1 DEN: onul cenglicengton ha-ko icey ku taum-pwuthe kunyang
today cleaning do-CONN now that next-from just
Today we’ll do cleaning and from then on it’s just

2 (0.5)

3 DEN: *yeki +yoko- yoko-ey Δmac-key
here this this-at fit-RESUL
Here this- to follow this
den *((moves hands to pick up chart))
nur +((moves hands to take hold of drape))
pat  \( \Delta((\text{looks at chart})) \)

4  (.)

5 DEN:  (il nyen-ey) sey kay.
       one year-TEMP three unit
       Three {teeth} (in a year).

6 PAT:  °ney.°
       yes
       °Yes.°

7  (1.0)

8 DEN:  ppay-ya-ci.
       extract-NECESS-COMM
       We should extract.

...  ((Thirty two lines omitted – DEN and PAT discuss
       treatment plan))

41 DEN:  amthun (0.2) olunccok-itun  oynccok-itun  ppalli
       anyway right.side-whether left.side-whether quickly
       mek-ul  tey  han kwuntey-nun malyen(h)-ul(h)
       eat-ATTR place one place-TOP  secure-ACC

       hay-nwa(h)-ya  tway
       do-complete-NECESS become

       Anyway (0.2) whether it’s right side or left side
       we should(h) quickly make(h) either part become able to
       chew properly

42 PAT:  ney.
       yes
       Yes.

43  (0.8)*(.)+(0.3)

den  *( (moves hand to pick up dental mirror))
nur  +((moves hand to cover PAT’s face))

44 NUR:  +elkwul tephe-tuli-ikey-yo?
       face  cover-HON-INT-POL
       {I’ll} cover {your} face?\(^7\)

       nur  +((raises drape high up; Figure 7))

\(^7\) Since Korean language uses zero anaphora, the nurse does not formulate the subject ‘I’ here, which is the unmarked referential choice (Oh, 2002). The referent is clear from the context, however, as the nurse herself is visibly engaged in covering the patient’s face.
After discussing what to do for treatment (data not shown), the dentist summarizes the most urgent thing to be done (line 41), which the patient acknowledges with “yes” n ey (line 42). As the dentist moves his hands to pick up a dental mirror (line 43), the nurse correspondingly moves her hands to unfold the drape she has been holding (line 43), orienting to the dentist’s embodied action (i.e., picking up the dental mirror) as projecting a transition to examination. As with Extract 11, it is mainly by virtue of the dentist’s embodied conduct that the nurse conclusively determines when to cover the patient’s face.
Subsequently, the nurse states that she will cover the patient’s face (“I’ll cover your face?” in line 44) while placing the drape.⁸ The onset of this turn occurs when the drape is lifted high up, right before it is put on the patient’s face (line 44; Figure 7). Arguably, the nurse produces the turn at this point partly because the patient is still opening her eyes even when the drape is about to be put on her face. By announcing the drape placement, the nurse lets the patient know what is happening and elicits the patient’s cooperation. The nurse indeed slows her hand movement while producing the turn so as to allow more time for the patient to close her eyes and be prepared. Note also that the nurse designs her turn in a way that articulates what she will do, instead of what the patient should do (e.g., “Close your eyes”), thus relying on the patient’s ability to act accordingly with the ongoing procedure. In response, the patient produces a verbal acceptance (“yes” ńey in line 45), while the nurse finishes covering her face.

Furthermore, the nurse’s announcement alerts the dentist that the patient’s face will soon be covered. That is, in addition to ‘seeing’ the nurse’s embodied action, the dentist can ‘hear’ the announcement and be explicitly informed of the ongoing status of the examination setup. The nurse’s announcement therefore works together with her embodied action (of drape placement) to help the other parties understand what she is doing in relation to the transition-in-progress. In other words, talk and embodied action

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⁸ The nurse’s turn can be understood in several different ways. It can be heard as an announcement that calls for the patient’s cooperation/compliance or as an informing that does not require any recipient commitment (see Stevanovic & Peräkylä, 2012). It can also be treated as a request seeking the patient’s granting response (see Stivers & Rossano, 2010). One difficulty in analyzing this turn is that it is unclear how the patient has understood the nurse’s action: Her verbal response ńey (line 45) can serve as a compliance token or an information receipt. I have interpreted the nurse’s turn as an announcement because it simply declares what she will do, and the patient, albeit minimally, displays cooperation by remaining still and maintaining the examination posture so that her face can be covered (see Stevanovic & Peräkylä, 2012).
jointly work to help the co-participants understand that the drape is being placed and thereby the examination is forthcoming (see Robinson & Stivers, 2001).

Subsequently, the nurse and the dentist finish exam preparation in silence: The nurse turns on the exam light, and the dentist puts on his face shield and moves closer to the patient (line 46). Then, as the dentist touches the patient’s face, the patient opens her mouth (line 46). Here again, the patient determines when to open her mouth by relying on her sensory access to the environment – i.e., the touch of the dentist’s hands. This extract is therefore similar to Extract 11 in that the nurse and the patient determine when to implement their transition-relevant actions – placing the drape and opening the mouth, respectively – without relying on explicit verbal references to the examination. One important difference is that the nurse articulates that she will cover the patient’s face in order to notify the other parties of what she is doing and to prompt their cooperation with the formulated action.

In sum, when moving towards the dental examination, the nurses use talk to announce that they will cover patients’ face. In the case above, because the patient was ‘behind’ in cooperating with the transition-in-progress by keeping her eyes open, the nurse specifically announces that she will cover the face to deal with the transition problem. The nurses in my data usually announce what they will do, instead of instructing patients on what to do, thus relying on patients’ local knowledge and ability to make themselves ready. In addition, this verbalization achieves a “double duty” (Turner, 1974) in that it also notifies the dentist that the exam preparation is underway. The nurses’ announcement thus offers a communicative resource for the other parties, in
addition to the visible action, to understand what specifically is happening and what should be done to cooperate with the projected examination.

*Dentist’s announcement of exam initiation ‘before’ patient’s face is covered*

Although nurses manage to provide timely assistance for examination setup without dentists’ verbal references to the examination, dentists may still rely on verbal resources to secure nurses’ timely assistance. In my data, the dentist verbally announces the start of the examination when there are indications that the nurses may *not cover* patients’ face at the ‘right’ time. Although the nurses monitor the dentist’s and patients’ ongoing actions, it may not always be obvious whether the dentist and patient are ready to shift into examination and whether their conversation is over. Hence, the nurses sometimes end up remaining still until the time when the dentist is finishing his exam preparation. In these cases, the dentist verbalizes that he will begin the examination to direct the nurse – who remains on standby to cover the patient’s face – to go ahead and place the drape.

In Extract 13, for instance, the dentist announces that he will begin the examination to prompt the nurse to cover the patient’s face. Prior to this segment, the dentist talks about the patient’s ongoing symptoms, while standing, with the mask already put on (data not shown). He then sits down, talks more about the problems (data not shown), and discusses how to clean the teeth (lines 1-5). After producing a summative statement emphasizing the importance of teeth cleaning (line 5), the dentist projects a transition to examination by taking off his glasses and picking up the face shield in silence (line 6).
Extract 13: D072

1 DEN: ( ) cal ppay-ya-cyo. khulleyncing-(ul).
   well remove-NECESS-COMM:POL cleaning-ACC
   ( ) you need to remove {them} well. {Through} cleaning.

2

3 DEN: wetephik-ulo.
   Waterpik-with
   With Waterpik.

4 (0.2)Δ(.)
   pat Δ((nods))

5 DEN: ( ) hangsang khulleyncing-ieyyo.
   always cleaning-POL
   ( ) it’s always cleaning.

6 (.)*(2.5)*(1.2)+(1.0)
   den *((takes off glasses))
   den *((picks up face shield))
   nur +(holds drape; Figure 8))

Figure 8: The nurse takes hold of the drape

7 DEN: *ham po-1key+-yo?
   one.time look-INT-POL
   {I’ll} take a look?
   den *((puts on face shield))
   nur +(moves drape upwards; Figure 9))
Figure 9: The nurse unfolds the drape

Seeing the dentist picking up the face shield, the nurse takes hold of the drape. She keeps holding the drape, watching the dentist briefly adjusting the edge of the face shield in silence (line 6; Figure 8). Although the dentist has produced the summative statement in the previous turn and is engaged in exam preparation in silence, the nurse remains on standby, without moving her hands to unfold the drape. Thus, to prompt the nurse to proceed and cover the patient’s face, the dentist announces that he will “take a look” (line 7), while putting on the face shield at the same time. With the announcement of exam initiation, the dentist informs the nurse that he has nothing more to discuss with the patient and is ready to move on. Note that the announcement is produced while the nurse is holding the drape and before the dentist picks up a dental mirror. It thereby directs the nurse to go ahead and finish draping while the dentist retrieves the dental
mirror so that the examination can begin without delay. Verbal resources are thus deployed by the dentist to prevent potential delays in the nurse’s provision of assistance and in the activity transition.

In response, the nurse accelerates her equipment setup. She raises the drape before the dentist’s turn is complete (line 7; Figure 9), announces that she will cover the patient’s face and places the drape accordingly (line 8), and immediately turns on the examination light (line 9). Note that the nurse verbalizes her action of drape placement to inform the patient that his face will be covered and alert the dentist that she is now carrying out the action (see discussion of Extract 12). Meanwhile, the dentist briefly takes a look at the chart (line 8), picks up the mirror, and moves closer to the patient (line 9). He then begins his examination without delay, given that, at this point, the nurse has finished the setup and the patient opens his mouth as soon as the dentist approaches (line 9). In sum, this segment shows that the dentist’s announcement of exam initiation can indicate to the nurse – who awaits an appropriate moment to cover the patient’s face – his readiness to move on, directing the nurse to go ahead and finish draping ‘on time’.

The dentist’s announcement achieves a “double duty” (Turner, 1974) in that it directs the nurse to promptly cover the patient’s face while, at the same time, informing the patient about the start of the examination. This is achieved through, first, the design of the utterance because the dentist merely declares that he will “take a look” without explicitly telling a specific party to do a specific action; and second, the timing of the utterance because it is produced when the nurse remains holding the drape. With such design and timing of the utterance, the dentist makes the two recipients – the nurse and the patient – draw on their local knowledge to figure out which action is to be performed
by whom as an ‘appropriate next’. That is, the dentist’s turn relies on the other two
parties’ competent interpretation of what is relevant next, given the particular point of the
transition process. Here, the nurse responds by covering the patient’s face, given that it is
the foremost thing to be done to shift into the examination, and the patient refrains from
opening his mouth right away, given that his face has not been covered yet. The
participants thus orient to the routine order of actions in advancing the progressivity of
the transition.

Note also that the patient opens his mouth after the exam light is turned on and the
dentist moves closer (line 9), without the dentist’s or the nurse’s verbal request or
instruction. This shows that the patient, with his face being covered, relies on sensorial
access – such as noticing the light above him turned on and hearing the dentist’s wheeled
stool coming closer – to determine the right timing of opening his mouth. Consequently,
the dentist can proceed to conduct his examination without asking the patient to open the
mouth.

Likewise, in Extract 14, the dentist also explicitly verbalizes the start of the
examination to direct the nurse to cover the patient’s face. After a no-problem
confirmation is given by the patient in the beginning of the consultation, the dentist looks
at the chart and points out how many days have passed since the patient’s last visit (data
not shown). Then, while putting on a mask and tying its straps, the dentist explains that
he will see how the patient’s dental condition has changed (lines 1-3), projecting a
transition to the dental examination. In the meantime, the nurse prepares a drape by
putting it on the patient’s chest (line 1), and adjusts the height of the patient’s dental chair
(line 2) as well as the position of the exam light (line 3).
Extract 14: D084

1  DEN: *isipil maney ettehkey +pakkye-ss-nun-ci icy kuke twenty.days during how change-PAST-ATTR-if now that
          Now {I’ll see} how it has changed during the twenty days
          den  *{(puts on mask)}-->
          nur +{(puts drape on PAT’s chest)}

2  +{(1.0)}

3  nur +{(adjusts height of dental chair)}

3  DEN: m- m- cikum kkye-ss-+umyen isipil ( )- tongan kki-n
          now grow-PAT-if twenty.days during grow-ATTR
          ke-eyyo.
          thing-POL
          m- m- now if there is {plaque} that accumulated
during twenty days.

4  nur +{(adjusts position of exam light)}

4  (0.2)*(0.9)

5  den --*{(takes off glasses)}

5  DEN: ( ) isip isipil maney elma- elmankhum
          twenty twenty.days during how.much
          kkye-ss-nun-ci *icey kukes-(to) com po-ko,
          grow-PAST-ATTR-if now that-also bit look-and
          ( ) I’ll see how- how much has accumulated during the
          twenty days and,
          den  *{(moves closer to PAT)}

6  *(0.4)+(0.8)*(0.8)

6  den *{(starts to pick up face shield, looking at chart)}
6  nur +{(holds drape)}
6  den *{(lowers upper body to look at chart; Figure 10)}
After explaining the goal of his examination (lines 1-3), the dentist continues to prepare for the examination. He takes off his glasses (line 4) and moves closer to the patient while further clarifying that he will see how much plaque has accumulated (line 5). Then, the dentist picks up the face shield in silence, while looking at the chart (line 6). Correspondingly, the nurse moves her hand to take hold of the drape lying on the patient’s chest (line 6). At this point, the nurse only partially raises the drape and waits.
for the dentist’s readiness (line 6; Figure 10). This may be because, first, the dentist’s prior turn is syntactically incomplete (line 5) and second, the dentist keeps gazing at the chart, lowering his upper body even further for a moment to take a look at it (line 6; Figure 10). By remaining still, the nurse orients to the possibility that the dentist might say something more to the patient or take more time for his exam preparation.

Subsequently, to inform the nurse that he is ready to move on, the dentist announces that he will begin the examination (“I’ll take a look?” in line 7), putting on the face shield and turning his body to the patient at the same time. As with Extract 13, the dentist merely states that he will “take a look” without specifically asking the nurse to unfold the drape, thus relying on her knowledge and ability to provide the relevant action. Furthermore, the dentist produces the turn before he is completely ready – i.e., before picking up a dental mirror – so as to have the patient’s face covered by the time when he picks up the mirror and actually gets to start the examination.

In response, the nurse lifts the drape (line 8) and notifies the patient that she will cover her face (line 9). Again, with her announcement of drape placement, the nurse not only informs the patient about what is happening but also lets the dentist know that she is now implementing the formulated action (see discussion of Extract 12); and meanwhile, the dentist picks up the dental mirror (line 9). Hence, this segment also shows that the dentist can announce the start of the examination to direct the nurse – who is assessing the right moment to cover the patient’s face – to go ahead and implement the action so that the examination can begin without delay.

Note again that the patient opens her mouth (line 11) right after the nurse covers her face, without the dentist’s or the nurse’s verbal request or instruction to do so. This is
possible partly because the patient has seen the dentist putting on the face shield and turning the body toward her (line 7) before her face is covered. The patient can thus anticipate that the examination will begin as soon as her face is covered and thereby time her action (of opening the mouth) correspondingly to the co-occurring actions.

The dentist’s announcement of exam initiation can also be produced when nurses get distracted from the ongoing business, which is illustrated in Extract 15. Here the dentist starts putting on the face shield even before initiating conversation (line 1), getting ready for the examination and the treatment at the visit’s opening. The nurse thereby immediately moves her hand to grab the drape lying on the patient’s chest (line 2; Figure 11), orienting to the imminence of the examination. She keeps holding the drape instead of covering the face right away because the dentist asks for a no-problem confirmation from the patient (line 2), which requires the patient’s response.

**Extract 15: D091**

1 ((DEN turns head toward PAT, putting on face shield))

2 DEN: +thekpyelhi +pwalphyenha-n ke-n
   particularly uncomfortable-ATTR thing-TOP
   eps-cyo.
   not.exist-COMM:DEF

   **Nothing is particularly bothering you, right.**

   nur +((moves hand))+((grabs drape; Figure 11))
3 PAT:  *yey.
       right
       Right.

den  *(puts on mask)-->  

4  

5 PAT:  °eps-  eps-sup-ni-ta°
       none  none-POL-DET-DECL
       °No- nothing°

6  

(1.2)+  

nur  +((changes hand from left to right to hold drape))  

7 DEN:  pok-i-ta  pok.
        luck-CP-DECL  luck
        Lucky you.

8 PAT:  +Eh  heh  ((laughs))  

nur  +((touches her head with left hand))  

9  

(0.4)*(0.3)  

den  -->*  

10 DEN:  °°Mm°  (.)  ham*  po-lkey-yo?
        DM  one.time  look-INT-POL
        °Mm°  (.)  {I’ll}  take  a  look?

den  *((touches drape; Figure 12))*((picks up tool))  

Figure 11: The nurse takes hold of the drape
Figure 12: The dentist touches the drape

\[\text{nur} \quad +((\text{unfolds drape}; \text{Figure 13}))\]

Figure 13: The nurse covers the patient's face

11 \hspace{1cm} (2.2)

12 DEN: \hspace{0.5cm} ayu pok-iey-yo pok+
DM \hspace{0.5cm} luck-ia-POL \hspace{0.5cm} luck
Ah lucky you

\[\text{nur} \quad --\to+\]

13 \hspace{1cm} *(0.5)

\[\text{den} \quad *((\text{moves closer to PAT}))\]

14 DEN: \hspace{0.5cm} eti \hspace{0.5cm} *pwa-\Delta pwa-yo?
where \hspace{0.5cm} look\text{-}look:IMP-POL
\{Let me\} \hspace{0.5cm} \text{take a look}?

\[\text{den} \hspace{0.5cm} *((\text{touches PAT's mouth}))\]
\[\text{pat} \hspace{0.5cm} \Delta((\text{opens mouth}))\]
The patient then gives a confirmation (“Right” in line 3), and at the same time, the dentist starts tying the mask straps (line 3), continuing his exam preparation. While the dentist ties the straps, the conversation goes on: The patient re-does the confirmation (line 5), the dentist acknowledges it with an assessment “Lucky you” (line 7), and this prompts the patient’s brief laughter (line 8). Note here that the nurse moves her left hand to touch her head (line 8), engaging in a different activity irrelevant to the current business at hand, thus ending up using a single hand to hold the drape. Consequently, the dentist, after tying his mask straps, briefly touches the drape (line 10; Figure 12), which prompts the nurse to move the drape and cover the patient’s face (line 10; Figure 13). He additionally verbalizes the start of the examination (“I’ll take a look?” in line 10) while touching the drape and picking up the dental mirror (line 10). Thus, the dentist uses both talk and bodily action to call for the nurse’s action of covering of the patient’s face. By using multiple modes of resources, the dentist attempts to secure the nurse’s assistance and avoid delays in the activity transition.

In contrast to Extracts 13 and 14, here, the patient does not open his mouth after his face is covered and the dentist moves closer to him (line 13), and thus the dentist produces another turn that refers to the examination (line 14; see next subsection for further explication). The patient then opens his mouth while the dentist’s turn is produced, after which the examination begins.

To summarize, the dentist can explicitly announce the start of the examination to secure the nurses’ assistance in the examination setup. By announcing that he will begin the examination when the nurse remains holding the drape, the dentist can direct the nurse to go ahead and cover the patient’s face. The dentist produces the announcement at
the point at which he is almost finishing his exam preparation so as to obtain the assistance by the time he is fully ready for the examination. Verbal resources are thus employed to avoid or remediate delays in the nurses’ assistance and in the transition of activity. In designing his turn, the dentist merely states that he will take a look, without specifying which action should be performed by whom, thus relying on the nurse’s and the patient’s knowledge and ability to provide relevant preparation at the appropriate moment in the transition process.

*Dentist’s announcement of exam initiation ‘after’ patient’s face is covered*

Patients do not always open their mouth immediately after their face is covered with a drape. This is because the activity of dental examination does not always immediately follow: The dentist sometimes takes more time to get ready for the examination and/or talks to the patients even after the drape has been placed onto their face. Although patients can rely on their sensory access to the situation (e.g., sensing the light turned on, hearing the dentist approaching closer), it may not always be obvious exactly when to open their mouth especially because they are unable to see the other parties’ behavior. In these cases, the dentist verbally notifies patients of the start of the examination to have them open their mouth.

In Extract 16, the dentist announces that he will “take a look” (line 40) after the patient’s face is covered. In contrast to the extracts in the above subsection, here, the nurse covers the patient’s face without relying on the dentist’s announcement. This visit is opened as the dentist invites a no-problem confirmation from the patient (line 1), and the nurse takes hold of the drape soon after the encounter is opened – i.e., when the patient offers a no-problem confirmation (line 2). The nurse keeps holding the drape,
instead of unfolding it right away, because the dentist is still standing, looking at the chart (lines 3-6; Figure 14), and he articulates the word “then” kulemyenun (line 3), which projects further talk. Again, throughout the segment, the nurse continuously adjusts her manual action of handling the drape to coordinate it with the conduct of the dentist and the patient.

Extract 16: D149

1 DEN: thukpyelhi pwulphyenha-n tey-n particularly uncomfortable-ATTR place-TOP

eps-u-si-cyo.
not.exist-CP-HON-COMM:DEF

Nothing is particularly bothering you, right.

2 PAT: *[ney. right

[Right.

3 DEN: *[ney. +kulemyenun okay then

[Okay. Then

den *((looks at chart))---
nur +(grabs drape; Figure 14))

Figure 14: The nurse takes hold of the drape

4 (1.0)

5 DEN: cencheycekulo han pen overall one time just overall

6 (1.0)*
7

DEN: + (khulleyncing)-ha-nun *cengto-lo
cleaning-do-ATTR about-PT
sort of doing (cleaning)

nur + (moves drape upwards; Figure 15)

Figure 15: The nurse raises the drape upward

8

(0.2) + (0.8)

nur + (retracts right hand; Figure 17)

Figure 16: The dentist holds mask straps to tie
Figure 17: The nurse retracts her right hand

9 DEN: a yocum yeltayya ttaymwuney acwu eti DM lately tropical.nights because.of very Ah lately because of the hot weather at night

... ((Nine lines omitted – DEN ties the mask straps, takes off his glasses, and picks up the face shield while talking; NUR keeps holding the drape))

19 PAT: i- i-ka an +coha-ci-si-n ke-ey-yo? teeth teeth-NOM not good-become-HON-ATTR thing-CP-POL Teeth- {his/her} teeth has become bad?

nur +((retracts right hand; Figure 18))

Figure 18: The nurse retracts her right hand again

20 (1.2)

21 DEN: yeki-nun i-potanun ekkay-ka ikey mak this.one-TOP teeth-rather shoulder-NOM this really It’s not {his/her} teeth but the shoulder is really

22 (0.5)

23 PAT: a[: ((nods))]
oh
92

Oh: ((nods))

24 DEN: [mak ilehkey mos wumcik-iko
really like this not.able move-CONN
really like {it} doesn’t move and
...
((Seven lines omitted – DEN talks about his other patient))

32 DEN: nay-ka(h) ku ku pwun-un an ppay-ko-to
I-NOM that that person-TOP not pull.out-CONN-be
ka-l swu iss-ul ke-la-ko
stay-ATTR way exist-ATTR thing-DECL-COMP

I(h) thought that person will be okay without
pulling out teeth

33 (0.3)

34 DEN: icy aphulo phyengsayng ka-l swu iss-ul
now from.now.on lifetime stay-ATTR way exist-ATTR
*ke-la-ko sayngkak-ul hay-ss-ess-nunrey
thing-DECL-COMP think-ACC do-PAST-PAST-CIRCUM

that for life from now on he will be okay but

den *{(puts on face shield)}

35 DEN: *ewu +ipen yeltayya-ka acwu mwusep-ney.
DM this.time tropical.night-NOM really horrible-FR
wow the hot weather at night this time is really horrible.

den *{(moves hand to pick up dental mirror)}
nur +{(moves right hand)}

36 (.)

37 NUR: +elkwul com tephe-tuli-lkey-yo?
face a.bit cover-HON-INT-POL
{I’ll} cover {your} face?

nur +{(covers PAT’s face; Figure 19)}-->
When the dentist sits on the chair and withdraws his gaze from the chart (line 6), the nurse raises the drape she has been holding (line 7; Figure 15), thus orienting to the dentist’s action of sitting down as an indication of the imminence of the examination. Yet, she remains holding the drape (line 7; Figure 16) possibly because the dentist’s ongoing turn regarding the treatment plan is syntactically incomplete (line 7). Then, while the dentist ties his mask straps, the nurse retracts her right hand a bit, resting it on the left hand’s finger (line 8; Figure 17) so that she can wait for the dentist to complete his turn and to finish tying the mask straps, and then she can cover the patient’s face as soon as the dentist is ready.

In the following turn, while continuing to tie his mask straps, the dentist shifts the conversational topic to non-task matters (line 9). He delivers a rather extended telling that is irrelevant to the task at hand, while still advancing his exam preparation by tying the mask straps, taking off his glasses, and picking up the face shield (data not shown); and thus the nurse continues to hold the drape, being on standby awaiting the appropriate moment to cover the patient’s face (data not shown). Subsequently the patient – who has been listening to the dentist’s talk – asks a question about the person being talked about
This question suspends the ongoing transition in two ways: First, it requires elaboration from the dentist, making the ongoing topic talk proceed further, and second, the dentist momentarily suspends his embodied action of putting on the face shield to look at the patient (line 19; Figure 18). Accordingly, the nurse retracts her right hand further (line 19; Figure 18), which exhibits her reasoning that the ongoing sequence of talk may expand longer than she previously expected and the transition will thus be more delayed. In the following turns, the dentist answers the patient’s question (lines 21 and 24) and continues to talk about his other patient (data not shown).

Then, while still talking about his other patient, in line 34, the dentist puts on the face shield that he has been holding, resuming the exam preparation that was held in abeyance; and as he sums up the talk-so-far (line 35), the dentist moves his hand to pick up the dental mirror. Correspondingly, the nurse also moves her hand to unfold the drape (line 35). The nurse thereby determines when to cover the patient’s face by closely monitoring the dentist’s conduct as well as the ongoing dentist-patient interaction. She goes ahead when the dentist is nearly finishing his exam preparation, and his talk with the patient, thus completing her action by the time the dentist is fully ready for the examination. In addition, the nurse verbally announces her drape placement (line 37) while placing the drape onto the patient’s face (lines 37-39; Figure 19), making her ongoing action known to the other parties and prompting their relevant cooperation (see discussion of Extract 12). In this way, the nurse provides timely assistance without relying on the dentist’s verbal reference to the examination.

Note here that the patient does not open her mouth immediately after her face is covered and the dentist moves his wheeled stool closer (line 39). Consequently, the
dentist announces that he will “take a look” (line 40), and the patient opens her mouth while the dentist’s turn is produced (line 40). The dentist uses the same form of utterance (ham polkeyyo “I’ll take a look”) as in the extracts in the above subsection, which states that he will take a look, without telling a specific party to perform a specific action. However, here, the turn is produced when everything has been set up for the examination and the only thing left is to have the patient’s mouth open. Therefore, it is the patient who responds to the dentist’s announcement by opening her mouth. Hence, we can see that, depending on its precise timing within interaction, the dentist’s verbal announcement of exam initiation can enlist a different party for a different action. This reveals the participants’ tacit orientation to the particular order of actions that are successively made relevant in their move towards the dental examination.

Similarly, consider again Extract 15, which I discussed previously. Here, the dentist first produces an announcement of exam initiation while the nurse is holding the drape, which serves to direct the nurse to unfold the drape and cover the patient’s face (line 10; see previous discussion of this extract). Then, after the nurse finishes drape placement, the dentist produces another turn that refers to the start of the examination (line 14), which, this time, serves to direct the patient to open his mouth.

Extract 15: D091

1  *(0.3)

den  *((turns head toward PAT, putting on face shield))

2  DEN:  thekpyelhi  +pwulphyenha-n  ke-n
  particularly  uncomfortable-ATTR thing-TOP
  
  eps-cyo.
  not.exist-COMM:DEF

  Nothing is particularly bothering you, right.
nur + (grabs drape))

3 PAT: *yey.
    right
    Right.

den * (puts on the mask) -->

4 (0.2)

5 PAT: "eps-eps-sup-ni-ta" none none-POL-DET-DECL
    "No- nothing"

6 (1.2)

7 DEN: pok-i-ta pok.
    luck-CP-DECL luck
    Lucky you.

8 PAT: Eh heh ((laughs))

9 (0.4)*(0.3)

den -->*

10 DEN: "Mm" (. ) ham* po-lkey-yo?
    DM one.time look-INT-POL
    "Mm" (. ) {I' ll} take a look?

    den * (picks up tool)
    nur + (covers PAT's face) -->

11 (2.2)

12 DEN: ayu pok-iey-yo pok+
    DM luck-is-POL luck
    Ah lucky you

    nur -->+

13 *(0.5)

den * (moves closer to PAT))

14 DEN: eti *pwa-Δpwa-yo?
    where look-look:IMP-POL
    {Let me} take a look?

    den * (touches PAT's mouth)
    pat Δ((opens mouth))

In this segment, the patient does not open his mouth for inspection even after his face is covered (lines 10-12) and the dentist moves closer (line 13). Thus, to direct the
patient to open the mouth, the dentist produces a request (“Let me take a look?” in line 14). Compared to the previous announcement in line 10, the dentist’s turn in line 14 similarly informs the patient of the start of the ‘looking’ process. However, as it is produced after the patient’s face is covered, along with the dentist’s touching of the patient’s mouth, this time it directs the patient to open the mouth. We can therefore see again that, although the similar form of utterance is used by the dentist to refer to the start of the examination, the nurse and the patient act upon the utterance differently depending on its precise placement in the ongoing activity. That is, they orient to the specific demands at a given moment and carry out their action correspondingly to accomplish the transition in a timely manner.

In sum, when patients do not open their mouth after their face is covered and the dentist moves into the position for the examination, the dentist explicitly refers to the examination to direct the patients to open their mouth. Given that the patients are unable to see the other parties’ behavior, the dentist’s announcement (or request) serves to let the patients know that it is time to open their mouth. In designing his turn, the dentist merely states that he will “take a look”, instead of telling the patients to open the mouth. In so doing, the dentist relies on the patients’ procedural knowledge and ability to provide the relevant next action at the given moment in the transition process.

In Extracts 12 through 16, dental professionals use talk to announce their forthcoming action when the other parties’ cooperation is not immediately undertaken. That is, verbal resources are used in response to the other parties’ lack of cooperation

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9 The dentist’s turn is in a *pwa* imperative form which is used as a request as part of a larger activity in progress (S. H. Kim & M. S. Kim, 2020). The formulated action (i.e., to “take a look”) requires the patient to open the mouth.
with the projected transition (Robinson & Stivers, 2001). Notably, dentists and nurses articulate what *they* will do, instead of what others should do, displaying an assumption that their co-participants can relevantly respond to the formulated action. Moreover, their announcement is precisely timed to secure others’ cooperation ‘before too late’. In this way, activity transitions are unproblematically accomplished with the help of verbal references to the examination.

**Summary and Discussion**

In this chapter, I have shown how dentists, nurses, and patients collaborate in initiating the activity of dental examination. The transition to dental examination can be accomplished without explicitly referring to the examination because participants closely monitor each other’s embodied conduct and the use of objects, in addition to ongoing talk, and make relevant and timely preparations for the examination. For instance, the nurses cover the patients’ face with ‘on time’ by carrying out the action when the dentist is almost ready for the examination and/or the dentist-patient conversation is coming to an end. Patients also open their mouth at the ‘right’ moment by implementing the action upon hearing the dentist approaching closer or feeling the dentist’s hands on their face. Yet, dental practitioners explicitly refer to the examination when the other parties do not immediately undertake required actions. These findings are thus generally in line with Robinson and Stivers’ (2001) observation that physicians use verbal references to the activity transition in response to patients’ lack of cooperation with physicians’ transition-relevant embodied behaviors.

When using verbal references to the examination, dental professionals in the present study design their utterance in a way that articulates what *they* will do instead of
what others should do. There are more explicit ways of soliciting others’ cooperation (e.g., to instruct the patient to open his/her mouth), which would require less inferential work for the recipient to perform the relevant action. Instead, by articulating what they themselves will do, dental professionals display their presumption that the co-participants can competently produce required actions without being told what to do. This suggests that professionals tend to ‘over-suppose and under-tell’ when eliciting others’ cooperation with the transition, treating their recipients as knowledgeable about what should be done in response.

Overall, this chapter contributes to our understanding of what it means to be a competent actor in negotiating activity transitions in dental consultations. Dentist, nurse, and patient are able to coordinate their way through the transition steps smoothly by monitoring emerging actions and following the routine trajectory of the transition. For instance, the drape has to be placed onto patients’ face before the examination begins, but exactly when it is placed reveals the nurses’ sensitivity to the moment-by-moment contingencies of interaction. When a delay is expected to occur, the dentist is able to produce announcements of exam initiation to facilitate the others’ actions. Upon the dentist’s announcement, the nurses and patients can figure out which specific action is to be performed by whom based on their procedural knowledge and ability to properly respond to the particular demands at hand. It is, therefore, part of participants’ competencies to make relevant contributions to the in-situ process of activity transitions by orienting to both local circumstances and the routine order of the transition steps. Since such transition steps (i.e., retrieving tools, placing a drape, and opening the mouth) are ordinarily familiar not only to professionals but also to patients as a matter of
Repeated experience, dental patients can participate as competent actors in the accomplishment of activity transitions.

Furthermore, this study shows how dental professionals coordinate their work while remaining sensitive to the ongoing interaction with patients. In handling a face drape, the nurses monitor the dentist’s preparation of examination-relevant objects while keeping track of the ongoing dentist-patient interaction. This is demonstrated through the nurses’ precise hand movements (e.g., remaining to take hold of the drape) in accordance with the dentist’s and patients’ ongoing actions and interaction. The nurses routinely adjust their action of unfolding the drape by accelerating, retarding, and suspending the developing action so as to coordinate it with the conduct of the dentist and patients (see Lerner & Raymond, 2017). In addition, the dentist’s announcement of exam initiation is designed and timed to achieve a double duty – i.e., facilitating the nurses’ exam preparation and informing patients of the start of the examination. In this way, dental professionals collaboratively set up for examinations while engaging with patients, being attentive to multiple tasks and activities at the same time. This study opens venues for further research into interaction among medical professionals, activity transitions, and the organization of dentist-nurse-patient interaction to investigate ways in which activities are coordinated and organized in clinical settings.
Chapter 6: Delivering Evaluations of Patients’ Oral Hygiene

Introduction

Maintaining good oral hygiene is the key to success in controlling dental caries and periodontal disease. Studies in the field of dentistry have examined ways to improve patients’ oral hygiene behavior to help them achieve optimal dental health. Behavioral interventions have been developed and tested by using approaches from psychology to improve patients’ self-management, such as flossing, tooth brushing, and dental visiting habits (e.g., Kakudate et al., 2009; Tedesco et al., 1992). Previous studies, however, do not explain how dentists and patients discuss oral hygiene results in real time or how dentists deliver evaluations of patients’ oral hygiene during dental consultations. Delivering evaluations of patients’ oral hygiene is a delicate activity because it commonly involves dentists’ praise or criticism of patients’ own behaviors (Milgrom et al., 1989). Dental professionals may need to manage carefully the moral implications of linking patients’ dental condition with their behaviors, while simultaneously motivating them to implement good oral hygiene habits. This chapter examines how dentists deliver oral hygiene evaluations in ways that are sensitive to the moral dimensions of patients’ self-management.

Among various tools and objects used in dental clinics, an intraoral camera – a tiny camera that looks like a pen and can be moved around inside the mouth – is frequently utilized to capture images of patients’ dental problems, such as dental plaque, defective fillings, or tooth decay. Intraoral cameras are widely used by dental practitioners in Korea (and other countries) to show patients what practitioners see and help them understand diagnosis, treatment planning, oral hygiene instructions, and
maintenance (e.g., Forgie et al., 2003; Willershausen et al., 1999). In this chapter, I will examine how the dentist uses the intraoral camera to show patients images of their dental plaque, guiding them to recognize their oral hygiene problems via visual aids. Notably, intraoral photos are presented only to patients with ‘poor’ oral hygiene, whereas they are not used for patients with ‘good’ oral hygiene. I will explicate the systematic ways in which ‘good’ and ‘bad’ oral hygiene results are presented differently to patients, focusing on the dentist’s management of the moral implications of oral hygiene evaluations.

This chapter is organized as follows. I first review relevant literature on issues of morality in medical interactions, discussing how providers and patients invoke a sense of patients’ moral accountability to take care of their health. I then present an analysis of how the dentist evaluates ‘good’ and ‘bad’ oral hygiene differently in ways that orient to patients’ ‘success’ and ‘failure’ to control dental plaque. I show that the dentist straightforwardly delivers positive evaluations of oral hygiene whereas he avoids articulating negative evaluations. The dentist holds an additional, post-treatment session with patients with poor oral hygiene to account for the evidential basis of his unfavorable evaluation by presenting intraoral photos. I argue that, through this ‘extra’ interactional work, the dentist avoids displaying an overt judgment about patients’ poor self-management, and works to maintain solidarity with them, while motivating patients to reflect upon their oral hygiene habits.

**Background**

**Morality in Medical Interactions**

Broadly, CA research has explored ‘morality’ as it emerges in talk-in-interaction, rather than as something omnipresent, focusing on participants’ orientation to issues of
what is right and wrong, desirable and undesirable, appropriate and inappropriate, and so on (Bergmann, 1998; Heritage & Lindström, 1998). Of particular relevance to this chapter are issues related to patients’ responsibility to appropriately care for their own health. CA studies have shown that providers and patients attend to patients’ obligations to perform appropriate self-care when discussing their health behaviors (e.g., diet, smoking, or exercise) or medical conditions closely related to their lifestyle (e.g., diabetes, HIV). Patients can be held accountable for their “medico-moral deficiencies or derelictions” (Stivers & Heritage, 2001, p. 161) as their problematic behaviors can be talked about not just in medical terms but also in moral terms. Providers and patients thus work to carefully manage moral evaluations, judgments, and claims associated with patients’ self-care performance.

Previous research has shown that providers and patients orient to the delicacy of talking about patients’ poor health behaviors. For instance, in general practice consultations, patients resist doctors’ negative assessment of their smoking to avoid being held accountable for their illness; and in the face of patient resistance, doctors usually stop pursuing the topic of smoking (Pilnick & Coleman, 2003). When patients disclose their own problematic health behaviors (e.g., poor diet), they show reluctance to report their behavior through speech disfluencies, such as pauses, stuttering, and reformulations (Bergen & Stivers, 2013), and use remedial strategies to present themselves as reasonable and health-minded (Denvir, 2014). Patients, for instance, display that they know their behavior is undesirable, indicate that they did it only in the past, or attribute the reason for their behavior to something external rather than their own choice (Denvir, 2014). In addition, when patients portray their lifestyle as normal and healthy, doctors usually
avoid questioning or resisting patients’ own evaluation (Denvir, 2012; Sorjonen et al., 2006). These studies therefore indicate that providers and patients orient to talking about poor self-management as interpersonally sensitive, working to avoid moral characterization of patients and potential damage to provider-patient relationship.

Although health behavior discussions can be difficult and delicate, they are often an essential part of consultations for chronic diseases. Patients with diabetes, for instance, are expected to follow treatment regimens, involving diet, exercise, and medications, and to write their daily blood glucose levels (BGLs) in their logbook to be reviewed by physicians. During consultations, both practitioners and patients treat BGL results as “an occasion for medical judgment leading to praise, blame, or excuses” (Silverman, 1993, p. 218). For instance, practitioners sometimes ‘test’ patients’ diabetes knowledge and management skills based on their logbook records through various question formats. Patients displaying lack of knowledge, adherence, and motivation are treated as ‘non-compliant’ whereas those exhibiting mastery of their regimen are treated as ‘compliant’ (Lutfey, 2004). When presenting BGL results, physicians explicitly assess ‘good’ BGLs whereas they simply report numeric values of ‘bad’ BGLs to avoid direct criticism of patients (Montenegro & Dori-Hacohen, 2020). Furthermore, patients usually resist physicians’ suggestion of insulin as it implies patients’ failure to control BGL (e.g., Brod et al., 2009), and thus physicians work to tailor their communication to each patient’s illness trajectory to better negotiate treatment intensification involving insulin (Koenig et al., 2014). In sum, in diabetes encounters, patients’ medical conditions are seen as reflective of their self-management and thereby as occasioning moral evaluations of their success or failure in illness management.
Discussing oral hygiene problems in dental visits can be similar to BGL evaluations because oral hygiene conditions are also considered to be reflective of patients’ self-care behaviors, such as flossing and tooth brushing. Silverman (1993) points out this similarity by explaining that practitioners’ judgments of both the conditions of teeth and blood-sugar level are “treated as crucial, asserting the moral worth or otherwise of [patients’] performance” (p. 218). Yet, no interactional studies have looked at real-time interaction between dentist and patient to examine how oral hygiene issues are dealt with and negotiated in dental encounters. Delivering oral hygiene evaluations can be a morally sensitive matter because dentists can be seen as judges of patients’ self-care behaviors and capabilities. This chapter investigates the interactional practices used by the dentist to present oral hygiene evaluations, focusing on how moral implications are managed and attended to by participants.

Analysis

Analysis of the data revealed that the dentist delivers positive and negative evaluations of patients’ oral hygiene differently: Positive evaluations are produced as “preferred” actions whereas negative evaluations are produced as “dispreferred” actions. In conversation analysis, “preference organization” does not refer to the psychological states of interactants, but to a set of systematic practices for managing courses of action so as to promote social solidarity and avoid interpersonal conflict (for review, see Heritage, 1984; Pomerantz & Heritage, 2012; Schegloff, 2007). “Preferred” actions tend to be produced straightforwardly and without delay, whereas “dispreferred” actions are often delayed, mitigated, and/or accounted for. In my data, the dentist recurrently delivers positive oral hygiene evaluations in a straightforward and unhesitating manner whereas
he avoids stating negative evaluations. In what follows, I show how the dentist delivers positive and negative oral hygiene evaluations differently with an orientation to patients’ moral accountability for taking care of their oral health.

Positive Evaluations as Preferred Actions

Previous research has shown that compliments (or positive evaluations of others) can be produced immediately when the speaker has gained access to the referent under evaluation. For instance, interactants compliment co-participants on their publicly perceivable features (e.g., hairstyle or clothing) at the earliest possible opportunity in the openings of interaction (Pillet-Shore, 2021). Compliments can also occur as an expression of pleasure at the moment when the speaker is experiencing it (e.g., upon trying the food offered by the co-participant) along with tokens such as “oh” or gustatory “mmmh” (Golato, 2011). Because compliments satisfy recipients’ “positive face wants”, i.e. the desire for others’ recognition and affirmation (Brown & Levinson, 1987), they tend to be produced directly and without hesitation to enhance social solidarity. Likewise, in my data, the dentist delivers positive evaluations of patients’ oral hygiene directly and unhesitatingly. For instance, the dentist articulates positive assessments ‘on the spot’, i.e. while conducting the dental examination and treatment, uses explicit evaluative terms (e.g., “good”), and produces exclamations of amazement (e.g., “wow”). By producing positive evaluations outright, the dentist makes his praise be seen as sincere and genuine, working to promote social solidarity (Heritage, 1984b) and constitute a moment of ‘celebration’. These compliments are not responded to by patients because patients are physically unable to respond during the examination and treatment, with their mouths open and faces covered with a drape.
Extract 17 illustrates the dentist’s positive assessments of the patient’s oral hygiene produced during the examination and treatment. Prior to this segment, the patient gives a confirmation to the dentist that she has no new problems to report (data not shown). The dentist then reviews the patient’s dental history, pointing out from the chart that it has been about twenty days since the patient received a dental cleaning (lines 1-2). Based on this timeline, the dentist explains that the goal of his examination is to see how the patient’s oral hygiene condition has changed during those twenty days (line 4). While putting on his mask and face shield for examination (lines 4-10), the dentist further notes that any ‘new’ plaque he finds must have been formed during the interim period (line 6), and he will now check its amount (line 8). The dentist therefore projects from the outset that he will evaluate how well the patient has kept her teeth clean since last visit.

Extract 17: D084

1  DEN:  wuli-ka *(.) yuwel sipiil nal i ccok-ul han pen we-NOM June twelfth day this side-ACC one time
        sukeyilling-ul hay-ss-ess-nuntey, cleaning-ACC do-PAST-PAST-CIRCUM

          We did (. ) cleaning on this side on June twelfth and,
        den  *((points to chart))

2  DEN:  cikum (0.3) han isipil tway-ss-ketun-yo? now about twenty.days past-PAST-CORREL-POL
        now (0.3) it’s been about twenty days?

3  (0.6)

4  DEN:  *isipil maney ettehkey pakkye-ss-nun-ci icye kuke twenty.days in how change-PAST-ATTR-if now that
        Now {I’ll see} how it has changed during the twenty days
        den  *((starts putting on mask))

5  (1.0)

10 Typically in Korea, people receive dental cleanings every six months. In this visit, the dentist monitors the patient’s oral hygiene as part of the ongoing orthodontic treatment.
DEN: m- m- cikum kkye-ss-umyen isipil ( )- tongan now grown-PAST-if twenty.days during

kki-n ke-eyyo.
grown-ATTR thing-POL

m- m- now if there is any {plaque} that’s what’s accumulated during the twenty days.

(1.1)

DEN: ( ) isip isipil maney elma- elmankhum twenty twenty.days during how.much

kkye-ss-nun-ci icy kukes-(to) com po-ko, grown-PAST-ATTR-if now that-also bit see-CONN

( ) {I’ll} see how- how much has accumulated during the twenty days and,

*(2.6)

den *((picks up face shield))

DEN: *ham po-lkey-yo? one.time look-INT-POL
I’ll take a look?

den *((puts on face shield))

(0.2)

NUR: elkwul com tephu-lkey-yo? face bit cover-INT-POL
I’ll cover your face?

PAT: ney yes Yes

(3.0)

DEN: e kwaynchan-ta.
DM fine-DEF
Oh it looks fine.

(1.5)

DEN: ike an ccike-to.toy-keyss-ta. this not take-be.okay-DCT.RE-DECL
{We} don’t need to take photos of this.

(2.6)

DEN: ( )-un saykkaal-i ( )-kwunna, -TOP color-NOM -UNASSIM
( ) the color is ( ),
Soon after the dentist begins his examination, he asserts a ‘no-problem’
evaluation by assessing the condition of the patient’s teeth as “fine” kwaychan-ta (line
15). Note that there is no hesitation in the dentist’s manner of producing the assessment:
It occurs as soon as the examination begins, without mitigation, and includes an explicit
evaluative term “fine” kwaychan-ta. It is also prefaced with “oh” e which marks the
assessment as based on a just-now-noticed condition (Heritage, 1984a, 1998; Jefferson,
1978). The dentist then rules out the need to take intraoral photos (line 17), confirming
that no additional steps are needed to monitor oral hygiene problems – i.e., the steps
usually taken for patients with ‘poor’ oral hygiene to discuss intraoral photos (see the
next subsection). Continuing his examination, the dentist conveys his amazement about
how clean the teeth are through a response cry “Aww::” iya:: (line 21). The response cry
conveys the sense of having been blurted out involuntarily and spontaneously (Goffman, 1978; Wilkinson & Kitzinger, 2006), enacting ‘sincere’ displays of the dentist’s positive reaction to what he is currently observing. Altogether, through these “online comments” produced during the examination (Heritage & Stivers, 1999), the dentist delivers his positive evaluations immediately and unequivocally, and rules out the need to discuss or educate on the oral hygiene problem afterwards.

As the dentist finishes his examination by straightening up his upper body, he produces another response cry that displays his amazement (“Wow::” ewu:: in line 23). At this time, the response cry comes off as an upshot of what the dentist has observed, reviving the surprise displayed earlier and reinvoking the positive evaluation (Wilkinson & Kitzinger, 2006). He then formulates an assessment which is possibly hearable as comparing this patient’s case with those of other ‘bad’ patients (line 25) because the dentist was talking about the importance of self-management to other patients right before this consultation. The dentist moves on to the treatment procedure by receiving a dental drill from the nurse and looking into the patient’s mouth again (line 26). During the treatment, he again produces an on-the-spot evaluation of the condition of the teeth outright, with an elongated exclamation “wow::” wuwa:: and evaluative term “good” coh-ta (line 27). We can therefore see that the dentist repeatedly articulates positive evaluations of what he observes (or has just observed) during the examination and treatment (or the transition in between). By presenting his evaluation in such an ‘exposed’ fashion, the dentist makes his praise be seen as genuine and enthusiastic, and constitutes the activities of examination and treatment as a moment of celebration.
Whereas in Extract 17, the dentist’s positive assessments are produced without any apparent attribution of responsibility to the patient, in Extract 18, the dentist’s praise of the patient’s behavior is explicitly articulated. In this visit, the dentist and the patient first talk about the patient’s problematic tooth, after which the dentist briefly examines it and confirms that it looks fine (data not shown). Then, while conducting the treatment, the dentist offers a positive characterization of the patient, i.e. that she keeps her teeth clean (line 2). The dentist formulates a subject-side assessment by describing his personal opinion about the patient’s character, i.e. that he “likes” how she keeps her teeth clean (Edwards & Potter, 2017). Note that the dentist uses the word “really” cham to intensify the description of the teeth condition (“really clean” cham kkaykkushakey) and of his subjective state (“really like” cham coh-a), enhancing the positive valence of the assessment.

**Extract 18: D134**

1  ((DEN is conducting the dental treatment in silence))

2 DEN: cham kkaykkushakey kwanliha-sye kacikwu cham coh-a. really clean look.after-HON so really like-IE {I} really like that {you} keep {your teeth} really clean. ...
   ((DEN continues treatment for a minute, and tells NUR what to do for cleaning up))

3 NUR: tamwule-*po-sey-yo? close.mouth-try-HON-POL Close your mouth please?
   den *(puts down treatment tools))

4  (0.5)*(0.5)
   den *(picks up chart lying on PAT’s chest))

5 DEN: *ilehkey-man kwanliha-si-myen cham *hay-like.this.at.least manage-HON-COND really hayphi-intey hayphi. happy-CIRCUM happy
{I} would be really ha- happy {to see patients} take care of {their teeth} like this.

den *((takes off face shield)) *(stands up))

After conducting the treatment for another minute and instructing the nurse what to do for the clean-up procedure (data not shown), the dentist puts his tools down and finishes the treatment (line 3). While taking off his face shield and standing up from his stool, the dentist praises the patient again by describing how “happy” he is with the patient’s self-management, unlike that of other patients (line 5). Produced after the treatment is done, this utterance credits the patient, based on what the dentist has just observed, for her good oral hygiene condition. Note that the dentist uses the word “really” cham again to underscore the positively valenced word “happy” hayphi. Altogether, by claiming that he is happy and satisfied, the dentist implies that the patient’s good self-management is beneficial not only to the patient herself but to the dentist as well. Importantly, the dentist produces his compliments during, or immediately after, his observation of the patient’s teeth, and in upgraded forms, working to show that he is ‘truly’ satisfied. The patient does not respond to the compliment even when it is produced after the treatment (line 4) partly because she cannot see what the dentist is doing due to her face drape. The dentist indeed produces the compliment while standing up from his stool and leaving (line 4), which shows that he does not expect the patient’s response.

Extract 19 is similar to Extract 17 in that the dentist produces positive assessments during the examination, along with response cries such as “Aww” awu. The difference is that here the dentist explains possible reasons for the patient’s good plaque
control while conducting the treatment. Before this segment, the dentist and the patient exchange small talk, and the dentist initiates his examination in line 1.

**Extract 19: D123**

1. DEN: "po-ca."
   look-PROP
   "Let’s see."

2. (.)

3. DEN: awu k'aykkus- awu ike mam-ey tu-nta ike.
   DM clean DM this heart-at fond-DECL this
   Aww clean- aww I like this one.

4. (0.5)

5. DEN: awu: (i-) ippu-ta.
   DM beautiful-DECL
   Aww: it’s beautiful.

... ((14 seconds omitted - DEN gives directions to NUR quietly, which are inaudible))

6. DEN: *wi-ey-nun ( ) upper.side-at-TOP
   For the upper side ( )
   den *{(straightens up and puts down his tool)}

7. (1.0)*(1.0)
   den *{(receives dental drill handpiece from NUR)}

8. DEN: "a hay-pwa"
   DM do-try
   "Say ah"

9. (.)

10. DEN: aph- aph-ni ilehkey an kkye-se o-nun front front-teeth like.this NEG grown-so come-ATTR
   ( )-ka cham tumwu-ntey
   -NOM really rare-CIRCUM

   It’s really rare to see front teeth with little plaque accumulation like this and

11. (1.1)

12. DEN: ikey kwanli-lul cal ha-kena, ani-myen chim-i this care-ACC well do-or not-COND saliva-NOM
This {can be because} you take care of your teeth well, or you have thin saliva.

Or you drink a lot of water.

Then {plaque} doesn’t get accumulated much.

While examining the patient’s teeth, the dentist first displays his amazement with “Aww” awu and produces the positive assessment term “clean” kkaykkus- (line 3). Without completing the sentence, he utters “aww” awu again and points out the specific part that he likes (“I like this one” ike mam-ey tu-nta ike in line 3). In so doing, the dentist immediately formulates his subjective reaction to what he is seeing at the moment. While still examining the teeth, he delivers yet another positive evaluation with “aww:” awu: and the assessment term “beautiful” ippu-ta (line 5) that positively characterizes the teeth condition. The dentist’s favorable stance towards the condition of the teeth is therefore displayed through explicit and immediate positive assessments, along with exclamations of amazement.

The dentist finishes his examination, while giving some directions to the nurse (line 6), and receives a dental drill to start the treatment (line 7). While conducting the treatment, he further comments on the patient’s good plaque control. He treats the patient’s case as exceptional by claiming how rare it is to see front teeth as clean as this, with the use of the word “really” cham that highlights the rarity of such good cases (line 10). Possible reasons are then listed for such little plaque buildup: It can be because the
patient takes good care of her teeth or has thin saliva (lines 12). The dentist thereby claims that this outstanding condition may not necessarily be due to the patient’s self-care efforts but might be linked to other factors as well, such as thin saliva. Nonetheless, the dentist shifts the focus back to the patient’s successful self-management by pointing to the possibility that she may drink a lot of water (line 14) – which can result in “thin saliva” – thus at least potentially crediting the patient for her good oral hygiene. In addition, by providing these explanations during the treatment, the dentist indicates that no separate session is needed to explain oral hygiene issues – which he normally provides to patients with poor oral hygiene (see the next subsection). Instead, his comments are delivered ‘in passing’, i.e. while the patient is receiving the dental treatment with her mouth open, without requiring the patient’s response.

In sum, the dentist presents his positive evaluation of patients’ oral hygiene condition forthrightly and without delay: His evaluations are produced in simultaneity with his observation of the patients’ teeth, with the use of explicit evaluative terms, upgraded forms of assessments, and/or response cries that seemingly ‘blurt out’ impulsive emotional reactions. In addition, the dentist explicitly formulates his satisfaction with the patients’ dental condition and their self-management. By ‘exposing’ his evaluation in these ways, the dentist highlights the beneficial aspects of ‘good’ oral hygiene results and promotes affiliation with the patients, which in turn can motivate the patients to continue self-care efforts. Given the satisfying oral hygiene results, no intraoral photos are taken to monitor and discuss patients’ oral hygiene – which normally takes place in the delivery of ‘bad’ oral hygiene results. In the following subsection, I show how negative oral hygiene evaluations are delivered differently from their positive
counterparts, focusing on the ways in which intraoral photos are taken and presented to patients with ‘poor’ oral hygiene.

**Negative Evaluations as Dispreferred Actions**

Previous studies have shown that interactants treat the action of criticizing or negatively evaluating others as dispreferred. For instance, during parent-teacher conferences, teachers produce student-criticizing utterances in a non-straightforward manner through speech disfluencies and omission of explicit reference to the student (Pillet-Shore, 2016). In mentor-teacher conversations, mentors deliver their critiques by ‘going general’, i.e. by depersonalizing their advice and invoking larger pedagogical principles (Waring, 2017). By employing mitigation practices when criticizing others, interlocutors work to minimize “face-threats” (cf. Brown & Levinson, 1987) and forestall interpersonal conflict. Likewise, in my data, the dentist avoids articulating negative evaluations of patients’ oral hygiene and their self-management. Instead, he shows patients images of their dental plaque, directing them to ‘witness’ their problem first hand. These images are taken in the middle of the dental examination phase with an intraoral camera – a device used to capture digital images of patients’ teeth and gums – and are shown to the patients after the examination and treatment are done. With these photos that display plaque retention, the dentist presents visual evidence for his negative oral hygiene evaluation and leads his patients to draw their own conclusions. In so doing, the dentist avoids articulating overt judgment or criticism, while accomplishing the goal of informing patients about their ‘poor’ oral hygiene status.

Extract 20 illustrates the moment at which the dentist takes intraoral photos in the treatment room. Soon after the examination begins (line 1), the dentist stops his
examination and asks the nurse to hand the camera (line 3), putting down the examination-related tools (lines 4-5). The dentist formulates the reason for this suspension by stating that he needs to show “this” to the patient (line 5). Note that he avoids describing what the problem is by merely referring to it as “this” *ike, without explaining what “this” is.

Extract 20: D049 (Patient 1, treatment room)

1 DEN:  po-1key-yo? look-INT-POL I’ll take a look?

2 (2.0)

3 DEN:  khameyla com cwu-sey-yo camera  bit give-HON-POL Hand me the camera please

4 (0.2)*(0.8)

den  *((puts down dental mirror))

5 DEN:  *ike-n paye-tulye-ya toy-keyss-ta. this-TOP show-HON-NECESS become-DCT.RE-DEF I need to show you this.

den  *((takes off face shield))

6 (0.4)

7 DEN:  *(ikey cehuytul-i) encey ha-n ke-nya-myen, this we-NOM when do-ATTR thing-INTERR-COND The time when (we) took care of (this) was,

den  *((picks up chart))

8 (1.2)

9 DEN:  iwel kwuil nal hay-ss-te-n *ke. February ninth day do-PAST-RETROS-ATTR thing on February ninth.

den  *((puts down chart))

10 DEN:  iwel kwuil nal hay-ss-nuntey February ninth day do-PAST-CIRCUM We did {it} on February ninth and

11 (0.5)
12 DEN: yuk kaywel maney ilehkey tway-ss-ta(-nun ke) six month in like this become-PAST-DEC-ATTR thing it became like this in six months
13 (1.2)
14 DEN: "ike-nun°
this-TOP
"This is°
15 (2.5)*(2.5)

* (receives camera from NUR))
17 *(0.2)

* (adjusts camera towards PAT’s mouth))
18 DEN: yuk kaywel maney, six month in
In six months,
19 (3.0)
20 DEN: "pikyo (toy-nun)°
contrast become-ATTR
"{there’s} quite a contrast°

* (gives camera back to NUR))
21 (1.0)*(5.0)

* ((takes off glasses and picks up face shield))
22 PAT: ma- mangkacye-ss-eyo?
deteriorated-PAST-POL It de- deteriorated?
23 (0.4)
24 DEN: itta poye-tuli-lkey-jo.
later show-HON-INT-POL I’ll show you later.
25 (0.4)
26 DEN: itta kkok poye-tal-lako ha-sey-jo,
later make.sure show-ask-QU do-HON-POL Make sure that you ask me to show you later,
27 (. )
28 DEN: po- *poye-tuli-lkey-jo(h) hehheh
While waiting for the nurse to bring the camera, the dentist picks up the chart to review the patient’s dental history (line 7). He identifies from the chart the date when the patient last visited (lines 7-9) and estimates that it took six months to become “like this” (line 12) – which insinuates that the dental condition has become worse in the interim period. The dentist avoids explicating the current condition by referring to it as “like this” ilehkey (line 12), without further describing the state of affairs. In other words, while indicating that there is something problematic, the dentist refrains from explaining what it is, postponing a detailed discussion of it until later.

The dentist then receives the camera from the nurse (line 15), adjusts the camera position towards inside the patient’s mouth to take pictures (line 17), and gives the camera back to the nurse (line 20). Meanwhile, he conveys another implicit evaluation of the patient’s current dental condition by stating that there is a contrast between ‘before’ and ‘now’ (lines 18 and 20). Subsequently, while the dentist prepares to resume the examination (line 21), the patient – who has been silent, maintaining her examination posture with her face covered with a drape – asks whether her dental condition deteriorated, which shows that she indeed understood the dentist’s previous comments as a negative evaluation of her dental status. The dentist again avoids elaborating on the problem by not answering the question and, instead, by assuring the patient that he will
show her the pictures later (lines 24-28). Note that the word “show” poye- (lines 24, 26, and 28) indicates that the problem is something to be ‘shown’ rather than to be ‘explained’. Thus, without clarification of the problem and explicit evaluation of it, the dentist proceeds to resume the examination that was held in abeyance (line 30).

Later in the same consultation, the dentist and the patient come out to the lobby area after the examination and treatment are done, and discuss the pictures previously taken, as illustrated in Extract 21.11 Prior to this segment, the dentist reminds the patient of the exact date she last visited the clinic (data not shown). He then specifies how much time has elapsed since then (lines 1-3) and points to the pictures shown on the screen, explaining that “this” is the amount of plaque accumulated during the interim period (line 5). Instead of describing the amount of plaque buildup, the dentist directs the patient to see it in the photos, using the pronoun “this” ike along with a pointing gesture (lines 5-7). In so doing, the dentist avoids formulating an overt evaluation of the plaque accumulation but instead presents the visual evidence of it, leaving the patient to draw her own conclusions. The patient receives the dentist’s explanation of the photos with a neutral acknowledgement token (“Mm:” in line 6). After a brief silence (line 7), the patient asks for further clarification about what the pictures exactly show (line 8), indicating that the images are still in need of explanation.

**Extract 21: D051 (Patient 1, lobby area)**

```
1  DEN: ha- hayethun icey cikum yuk kaywel maney o-si-
   anyway now now six month in come-HON
   o-si-n ke-nteY,
   come-HON-ATTR thing-CIRCUM
```

11 Sometimes there are other patients waiting to be called by nurses in the lobby area. These patients may thus overhear the oral hygiene discussion held in the area, although it is hard for them to see the screen that shows intraoral photos.
Any- anyway now you came after six months and,

. .

ku-ntey yu- yuk kaywel *maney,
do.so-CIRCUM six month in
and in si- six months,

den *((moves hand to point to the screen))

(0.5)

*ikey kki-n sangthay-eyyo. [ikey.
this:NOM grow-ATTR state-POL this:NOM
This is how much has accumulated. This
den *((pointing gesture))-->

(Mm:

(0.2)*

den --=*  

chisek kki-n ke-yo?
tartar grow-ATTR thing-POL
Is this tartar accumulated?

(0.4)

phullaku acik-un (0.2) chisek-chelem tantanhayci-ci-n
plaque yet-TOP tartar-like hardened-COMM-TOP
anh-ass-eyo.
not-PAST-POL

It’s plaque it’s not yet (0.2) become hardened as tartar.

(1.0)

*kuntey,
but

But,

den *((moves computer mouse to open more photos))-->

(0.6)

icey i cengto-myen-un
now this level-COND-TOP
now if it’s this much

(6.0)

(kunikka)* yolen key cengsang-iketun-yo,
So this thing normal-

(So) this is what's normal,

den --*-

17 PAT: [Mm

18 DEN: [yoleh:::key[:

like this

[Like thi:::s:

19 PAT: [Mm mm

20 DEN: kuntey yeki-nun po-myen-un

but here-TOP see-COND-TOP

But if you see here

21 (0.2)

22 DEN: [mwe-

well

well-

23 PAT: [yay-ka alaysni-cyo.

this-NOM lower.teeth-COMM:POL

These are lower teeth, right?

24 DEN: alaysni an-[ccok.

lower.teeth inner-side

Inner side of the lower teeth.

25 PAT: [Δike?

this.thing

This one?

pat Δ((points to her lower teeth with fingers))

26 (.)

27 DEN: yey keki-yo.

yes there-POL

Yes there.

28 (1.0)

29 PAT: yeki-ka ilehkey pwtueisse-se kule-na?

here-NOM like this attached-so be.so-NCOMM

Is this because here it's attached like this?

... ((28 lines omitted - DEN and PAT discuss lower-teeth problems for about 1 minute))

58 PAT: kulem yeki ettehkey kwanli-lul hay-ya tway-yo,
then here how care-ACC do-NECESS become-POL

Then how should I take care of this area,

59 (0.5)
The dentist answers the patient’s question, indicating that plaque is generally easier to remove than tartar (line 10), but then produces the contrast marker “but” kuntey (line 12) to return to the problematic aspect of the patient’s dental plaque. Looking at the pictures, the dentist refers to the amount of plaque as “this much” (line 14), which implies that it is a lot, without directly describing the amount. Here, the dentist initiates a conditional clause (“now if it’s this much” in line 14), which projects a formulation of what the plaque amount indicates in the main clause, but he does not complete the sentence. Instead, the dentist opens the post-treatment photos of the patient’s teeth taken six months ago, introducing the photos as depicting the “normal” condition (line 16). He then points back to the pictures taken that day, using the contrast marker “but” kuntey and the deictic “here” yeki (line 20), guiding the patient to ‘see’ the difference, without himself explaining the difference. A conditional clause (“But if you see here” in line 20) is again initiated, which projects a formulation of the difference between the photos; but again the dentist hesitates to produce the rest of the sentence (see the delay in line 21). We can therefore see that the dentist merely hints at his negative evaluation and never states it outright. Instead, the patient is made to see the images of the plaque with her own eyes and become aware of the problem. This also conveys the dentist’s claim that the
severity of the problem is obvious to a lay person, without the need for professional training to expertly read and interpret the images.

As the dentist’s formulation of the main clause of the sentence is delayed (line 21), the patient jumps in and asks if the pictures show her lower teeth (line 23), preempting the dentist from finishing the explanation of the photos. Following the dentist’s confirmation (line 24), the patient identifies a problem at the area to ask if it is the reason for the plaque accumulation (line 29). In so doing, the patient rejects the implied responsibility for the plaque retention. The discussion continues on the lower-teeth problem (data not shown) and goes back to the plaque issue when the patient asks how to take care of it (line 58). By displaying a stance of ‘not knowing’, the patient attempts to evade epistemic responsibility and to avoid being accused of neglecting self-care practices (Montenegro & Dori-Hacohen, 2020). In other words, she attributes her ‘bad’ dental condition to insufficient knowledge rather than a lack of effort. The patient further defends herself by claiming that she brushes her teeth as best as she can (line 61). Thus, we can see that the patient understands the dentist’s presentation of the photos as implying her lack of self-care efforts and thereby carrying a potential criticism.

Extract 22 is similar to Extract 20 in that the dentist stops his examination (lines 3-4) and asks the nurse for the intraoral camera (line 4), without giving much information to the patient about what is wrong. Here again, the dentist reports something problematic by stating that he needs to show “this” ike (line 6), without unpacking what “this” is. That is, the dentist merely projects that pictures will be taken and be “shown” to the patient, instead of describing what the problem is.
Extract 22: D078 (Patient 2, treatment room)

1 DEN: po-lkey-yo?
   look-INT-POL
   I’ll take a look?

2 PAT: ney:
   yes
   Yes:

3 \((2.1)*(0.5)\)
   den * ((starts putting down tool))

4 DEN: khameyla *cwu-sey-yo.
   camera give-HON-POL
   Hand me the camera please.
   den * ((shifts his stool away from PAT))

5 (.)

6 DEN: ike-n poye-tulye-ya-ci.
   this-TOP show-HON-NECESS-COMM
   I need to show you this.

7 \((0.8)\)

8 DEN: "ike-n"
   this-TOP
   "This is"

9 \((1.2)*(1.5)\)
   den * ((takes off face shield))

10 DEN: ike-nun poye-*tulye-ya-ci
    this-TOP show-HON-NECESS-COMM
    I need to show you this ((in a humming voice))
    den * ((walks out of the camera view))-->>>

After asking for the camera and informing the patient that there is something to be shown, the dentist takes off his face shield (line 9) and walks out of the camera view (line 10). Throughout the segment, the patient remains still and silent because she is lying on a dental chair with her face still covered with a drape, maintaining her examination posture. The dentist then comes back and takes intraoral photos without producing any comments about the problems he has found (data not shown).
Later in the consultation, the photos are shown to the patient in the lobby area, as illustrated in Extract 23. Just prior to this segment, the dentist briefly explains their treatment plan for the next visit (data not shown). He then pulls up the photos on the screen (data not shown) and starts to explain what the photos depict – i.e., the increased amount of plaque accumulation (lines 1-3). Note that the dentist does not use his own words to describe or assess the amount of plaque, but instead directs the patient to ‘see’ it herself by using the demonstrative expression “like this” ilehkey along with the pointing gesture (lines 1-5).

**Extract 23: D083 (Patient 2, lobby area)**

1. DEN: .hhhh tto ilehkey-again like.this
   .hhhh It’s again like this-

2. \((0.3)*(0.3)\)
   den *{(points to screen)}-->

3. DEN: kkye iss-ta-n mal-ieyyyo?
   grown exist-DEC-ATTR word-POL accumulated?

4. PAT: °ney.
   yes
   °Yes.

5. \((0.6)*(.)*Δ(0.4)*(.9)\)
   den *{(looks at PAT})
   pat Δ((nods))
   den -->*

6. DEN: kunikka cikum twu tal-i an-toy-n ke
   so now two month-NOM not-become-ATTR thing
   So it’s been less than two months now

7. PAT: °u- um°
   yes
   °y- yes°

8. \((1.0)\)

9. DEN: twu tal-i an-tway-ss-nuntey, \((0.2)\) yeki kkye-ss-e.
   two month-NOM not-become-PAST-CIRCUM here grown-PAST-IE
less than two months and, (0.2) here it’s accumulated.

... ((DEN explains for 30 seconds about what he did for treatment))

10 DEN: ike- (. ) twu tal cen-ey hay-ss-ten-ke-
this two month ago at do-PAST-RT-thing
this- (. ) from what we did two months ago-

(0.5)

12 DEN: eyse pipho-ka- icy eyphuthe-ka icy ike-ketun-yo?
from before-NOM now after-NOM now this-CORREL-POL
the ‘before’ one is- now the ‘after’ one is now this one?

13 PAT: [°( )°

14 DEN: [ikey cokum (. ) nama-ss-nuntey
this bit left-PAST-CIRCUM
There’s a bit (. ) left but

15 DEN: hwaktay-tway-se (poi-nun)-ke-nteey taypwupwun-un
zoom.in-become-so appear-ATTR-thing-CIRCUM most-TOP
cikum epsicye-ss-eyo.
now disappear-PAST-POL

that’s because it’s zoomed in and most of {the plaque}
is now removed.

16 PAT: °ney.°
yes
"Yes."

(2.2)

18 DEN: kuntey tto icy ettehkey Δkki-na icy po-ca-kwu-yo.
DM again now how grow-INTERR now see-PROP-CONN-POL
And now let’s see again how {plaque} grows.

pat Δ((nods))

19 DEN: =(ike-n chilwel phalil kke-eyyo),
this-TOP July eighth thing-POL
=(This one is July eighth),

20 PAT: °ney:.°
yes
"Yes:."

(.)

22 DEN: kulem ponin-uy ku supkwan-i nao-keyss-cyo.
then yourself-GEN DM habit-NOM reveal-DCT.RE-COMM:POL
Then we may find out what your habits are.

23 Δ(0.3)
After the patient acknowledges the dentist’s explanation of the photos with a quiet “yes” (line 4), the dentist turns his head and looks at the patient in silence, while still pointing to the photos (line 5). In so doing, the dentist visibly works to elicit and co-implicate the patient’s agreeing perspective in his negative evaluation of the oral hygiene condition (cf. Maynard, 1992). The patient responds by nodding (line 5), offering a minimal response and passing an opportunity to further talk to the dentist. She thereby displays her reluctance to fully accept and agree with the dentist’s implicit negative evaluation. The dentist further explains that this is what has been accumulated in “less than two months” (lines 6 and 9), indicating that the rate of plaque accumulation is ‘rapid’. Note that the dentist merely reports factual information (lines 1-3, 6, and 9), along with the use of the visual evidence, instead of articulating overt evaluations. He thereby displays an objective stance toward the matter at hand, leaving the patient to realize the meaning of the information being delivered, i.e. that her oral hygiene condition is ‘bad’.

Subsequently, the dentist starts to explain what he did for treatment (data not shown) and compares the ‘before’ and ‘after’ photos taken that day (line 12). He explains that most of the plaque is now removed in the ‘after’ photos (line 15), which the patient acknowledges with a quiet “yes” (line 16). The dentist then suggests that they keep monitoring plaque accumulation (line 18), formulating a plan of care and shifting to future business. Note that the dentist formulates his reasoning that their monitoring may help them find out the patient’s habits affecting her dental condition (line 22), which implicates the patient in her ‘poor’ oral hygiene status. The patient again offers a minimal
response with her head nod (line 23), withholding a fuller vocal response and passing an opportunity to take a turn. She thereby shows her reluctance to fully accept the dentist’s perspective that problematizes the patient’s self-care ability.

In sum, the dentist’s negative evaluation of the patients’ oral hygiene is only alluded to in his explanation of intraoral photos, without being stated outright. The dentist follows the principle of ‘show, don’t tell’ by presenting photos of patients’ dental plaque while avoiding formulating his evaluation of the plaque retention. With the use of the visual evidence, the dentist works to be seen as factual rather than subjective or judgmental, guiding the patients to see their problems and draw their own conclusions. This way of conveying evaluation can be compelling and powerful because it co-implicates the patients into witnessing their problems and provides reasons for the negative evaluation (cf. Peräkylä, 1998). At the same time, by manifesting difficulty articulating his evaluative utterances, the dentist avoids being overtly evaluative or ‘over-teaching’, minimizing the likelihood of potential conflict. The patients understand these additional sessions as well as the presentation of the intraoral photos as problematizing their self-management. They show this by withholding any assessments of the photos, defending themselves through a claim of self-care efforts, and avoiding full acceptance of the potential criticism carried in the dentist’s explanation of the photos.

**Summary and Discussion**

This study has illustrated the contrasting ways in which the dentist delivers positive and negative evaluations of patients’ oral hygiene: Positive evaluations are produced explicitly and at the moment when the dentist is observing patients’ teeth (i.e., during the examination and treatment) whereas negative evaluations are merely alluded
to in the dentist’s presentation of intraoral photos after the examination and treatment are done. Compared with how he delivers positive evaluations, the dentist cautiously manages the delivery of negative oral hygiene evaluations by suppressing the articulation of unfavorable assessments, and instead, by presenting evidence that visualizes patients’ dental plaque. The dentist thereby accomplishes the goal of informing patients of their ‘poor’ oral hygiene status without criticizing their self-management.

By delivering positive and negative evaluations in systematically different ways, the dentist maintains social solidarity and encourages patients to perform self-care. In cases of positive evaluation, the dentist works to make his praise be seen as genuine and enthusiastic to display affiliation and support for patients’ self-care efforts. For instance, by producing favorable assessments and response cries at the moment when he is looking at patients’ teeth, and at various points during the examination and treatment, the dentist works to authenticate his expression of admiration and astonishment. Previous research on “online commentary” – i.e., doctors’ comments about what they observe during the physical examination – has focused on its role in reassuring patients about their health status and preempting patient resistance to an upcoming ‘no-problem’ diagnosis (Heritage & Stivers, 1999). The findings of this study extend our understanding of the functions of online commentary by showing that providers’ online evaluations of patients’ condition can serve to praise patients for their success in self-care at the earliest possible opportunity. As the dentist works to show that he is ‘truly’ amazed and satisfied with patients’ oral hygiene condition (and their self-management) through the on-the-spot positive evaluations, he enacts a strong display of affiliation with patients, which in turn can encourage them to continue self-care efforts.
In cases of negative evaluation, the dentist displays caution to minimize affront to solidarity. The dentist takes a ‘show don’t tell’ approach by showing patients images of their plaque instead of telling them what is wrong. As the dentist presents visual evidence instead of articulating negative assessments of patients’ oral hygiene, he works to avoid being seen as judgmental or patronizing. At the same time, patients can be informed about their ‘poor’ oral hygiene status because the problem is made apparent through the images of dental plaque. Previous research has shown that clinicians provide patients with evidence-based formulations, rather than plain assertions, to establish a shared basis for the diagnosis when it involves uncertainty (Peräkylä, 1998) or its outcome has a negative valence (Maynard, 2004). Similarly in my data, the dentist provides evidential reasons for the negative oral hygiene evaluation “to achieve a sense of mutuality, understanding, and agreement about” the oral hygiene results (Maynard, 2004, p. 71). By achieving joint ‘seeing’ of patients’ problems with the use of visual evidence, the dentist proposes that the problems are objectively there, without displaying an overt judgment about the ‘poor’ oral hygiene status. In so doing, the dentist works to maintain solidarity while motivating patients to reflect upon their oral hygiene habits.

This chapter extends conversation analytic work on preference organization by demonstrating the dentist’s orientation to the valence – positive or negative – of oral hygiene results. Previous conversation analytic studies on ordinary and institutional interactions have shown that interlocutors formulate positively valenced states of affairs straightforwardly whereas they delay or avoid articulating negatively valenced states of affairs (e.g., Beach, 2002; Maynard, 2003; Maynard & Frankel, 2006; Montenegro & Dori-Hacohen, 2020; Pillet-Shore, 2016; Schegloff, 1988). Similarly, this study
contributes to advancing our knowledge about the preference for the delivery of positive oral hygiene evaluations and dispreference for negative evaluations in dental consultations. In evaluating the oral hygiene status, the dentist assesses patients’ self-management, which may involve either praising patients’ self-care (a preferred action) or (implicitly) criticizing their efforts (a dispreferred action). Hence, positive oral hygiene evaluations are oriented to as opportunities to promote the solidarity between dentist and patient whereas negative evaluations are treated as threatening the solidarity.

Furthermore, this study contributes to our understanding of how providers manage the tension between moral and institutional concerns when delivering health evaluations that are closely related to patients’ self-care. Providers try not to appear to be judgmental of patients’ self-management, while at the same time motivating patients’ self-care practices. As shown in the analysis, patients are explicitly credited for their ‘good’ health condition whereas they are not directly blamed for their ‘bad’ condition. Providers, instead, make additional efforts to establish a shared, objective basis for their negative assessments of patients’ health condition. These asymmetric modes of delivery can be beneficial not only for maintaining an affiliative relationship but also for prompting patients’ self-care practices. Patients can be motivated to engage in self-management through positive assessments and encouragement as well as through interpretation of negative medical results (Montenegro & Dori-Hacohen, 2020).

Especially with the use of visual aids, such as intraoral photos, providers can effectively establish the visibility and intelligibility of health problems, which in turn can motivate patients to reflect upon their self-care habits. My findings provide a foundation for further
work that would look into the effects of these communication practices on provider-patient relationships and health outcomes.
Chapter 7: Conclusions

Summary of Findings

This dissertation has explored how dentists, nurses, and patients in Korea jointly construct the dental visit on a moment-by-moment basis. Chapter 4 investigated the dentist’s first turn-at-talk that initiates interaction with patients. It was shown that the dentist uses either a task-oriented or a non-task-oriented first turn. Task-oriented first turns are designed to indicate the dentist’s prior knowledge of patients’ problems and thereby facilitate the move towards the dental examination and treatment. With these first turns, the dentist not only gets straight to the business at hand but also starts from the most urgent task based on what is known about patients’ dental history. Such ‘efficient’ moves towards the business of the visit may be linked the characteristics of Korean institutional encounters – which promote expeditious task accomplishment (Bailey, 2000; Park, 2013, 2017) – and to the unique body arrangements in dental settings (where patients are seated in a dental chair reclined to a horizontal position) which projects their imminent involvement in dental examination and treatment. On the contrary, the dentist’s non-task-oriented first turns initiate a ‘social’ opening to produce a more personalized encounter, postponing the launch of the dental business. Notably, in my data, all the non-task-oriented first turns reveal close relationships between dentist and patient. This suggests that, despite the general orientation to the ‘rapid’ progression of the consultation, enacting a familiar relationship between dentist and patient can become an overriding goal in opening the dental visit.

In Chapter 5, I have shown how dentists, nurses, and patients collaborate in initiating the activity of dental examination. The transition to dental examination can be
accomplished tacitly, i.e. without explicitly referring to the examination, because participants constantly monitor each other’s talk, embodied conduct, and the use of objects and make relevant contributions to the transition process. In particular, nurses pay close attention to the ongoing dentist-patient interaction and adjust their actions of preparing dental instruments accordingly. When the actions required for the transition are not immediately undertaken by the other parties, dentists or nurses may explicitly refer to the examination (see Robinson & Stivers, 2001). When referring to the examination, dental professionals announce what they will do for the start of the examination instead of asking others what to do. This shows their assumption that the co-participants are able to produce required actions without specifically being told what to do. The way dental professionals elicit others’ cooperation with the transition, therefore, treats the co-participants as knowledgeable about the routine order of the transition steps and capable of responding to the local demands.

Chapter 6 analyzed the contrasting ways in which the dentist delivers ‘good’ and ‘bad’ oral hygiene results to patients. Evaluations of ‘good’ oral hygiene are produced at the moment when the dentist is observing patients’ teeth through explicit assessments, compliments, and exclamations of amazement. In contrast, evaluations of ‘bad’ oral hygiene are merely implied, rather than stated outright, in the dentist’s presentation of intraoral photos after the examination and treatment activities are done. It was argued that, by delivering positive and negative evaluations in such different ways, the dentist preserves social solidarity and motivates patients’ self-management. More specifically, the dentist works to show that his positive assessments are genuine and sincere by producing them at the earliest possible opportunity and repeatedly during the examination
and treatment – thereby showing affiliation and support for patients’ self-care efforts. When delivering negative evaluations, the dentist works to avoid overtly criticizing patients’ poor self-management while informing them about their objective dental status with the use of visual evidence – thereby achieving mutual understanding and motivating patients to perform self-care.

**Implications**

*Implications for Communication in Dental Settings*

The findings presented in this dissertation show how provider-patient interactions in dental settings are distinct from those in other medical contexts. Dental consultations involve unique body postures and arrangements as patients are lying on a dental chair, surrounded by the equipment and machinery, with dentists and nurses being on each side of patients. These bodily and spatial arrangements indicate that participants orient to the activities of dental examination and treatment, rather than the activity of conversation, as ‘main’ and ‘dominant’ activities. Especially because patients’ lower body (torso and legs) is not oriented toward dentists, their engagement in conversation with dentists is projected to be fleeting and transitory (see Kendon, 1990; Robinson, 1998; Schegloff, 1998). Although patients’ gaze can be directed toward dentists via a head turn, their heads will need to be re-oriented to a forward-facing position to resolve the postural instability (see Schegloff, 1998). Participants’ body configurations thus facilitate ‘rapid’ progress towards the dental examination and treatment (as shown in Chapter 4). That is, the unique body arrangements involved in dental settings may promote the progressivity of the dental visit.
In addition, dental consultations are complicated by their triadic nature as interprofessional collaboration and provider-patient interaction occur in parallel. The presence of nurses, in particular, is an element specific to dental settings, which distinguishes dental encounters from dyadic doctor-patient encounters and from other triadic doctor-patient-companion encounters. The findings presented in Chapter 5 illustrate the unique role nurses play in dental consultations. I showed how nurses assist dentists in setting up instruments in ways that avoid interrupting the ongoing dentist-patient interaction. Nurses continuously monitor the ongoing interaction and assess what should be done and when, functioning as ‘assistants’ to the dentist. As part of their professional competence, nurses attend to interactional and situational contingencies so as to facilitate the performance of dental procedures, on the one hand, and to promote interaction between dentists and patients, on the other hand. Nurses’ role performance is part of what makes dental encounters as uniquely triadic.

Dental visits are also distinctive in that evaluating and discussing patients’ self-management is an essential component of care. Previous research in dentistry has claimed that the way providers discuss patients’ oral health condition can influence patients’ feelings of guilt and shame (Moore et al., 2004; see also Gale, 1972). In Chapter 6, I demonstrated that the dentist in my data carefully manages the moral implications of oral hygiene evaluations by presenting ‘good’ and ‘bad’ oral hygiene results in systematically different ways. In particular, the dentist makes additional efforts (e.g., taking intraoral photos) to deliver the ‘bad’ oral hygiene results so as to establish a joint understanding of the oral hygiene status of patients. The findings of Chapter 6 can be compared and contrasted with those in other clinical encounters that involve the evaluation of patients’
self-management, such as diabetes encounters. Also, based on the findings of Chapter 6, follow-up research can be conducted to understand how patients ‘feel’ about the ways in which oral hygiene results are presented by the dentist and to see if there is room for improvement.

**Implications for Korean Medical Interaction**

This dissertation has also identified interactional features that are specific to Korean medical contexts. We saw in Chapter 4 that, in the recorded dental consultations, there is absence of elements that are typically present in US or UK primary care consultations, such as greetings or opening solicitations of patients’ concerns. This is in line with previous CA findings that Korean primary care visits involve a reduction of typical consultation phases (Y. Park, 2017), which suggests that this could be a feature specific to Korean contexts. Furthermore, it has been shown how the characteristics of Korean medical consultations that previous research identified – that they are ‘short’ and involve ‘rapid’ patient turn over (e.g., Chae et al., 2009; Cho et al., 2004) – may emerge in actual stretches of talk. As illustrated in Chapter 4, the turn-design features of the dentist’s talk and their interactional consequences show precisely how the participants bypass other relevant activities (e.g., greetings, problem solicitation) and ‘efficiently’ progress through the consultation.

Overall, the findings presented in this dissertation indicate that what is considered to be ‘typical’ and ‘standard’ sets of activities in provider-patient communication may differ across cultures. Social actions that are treated as normal and appropriate in some cultures may not be so in others; and thus, it is important to understand the cultural norms to which providers and patients are oriented to achieve a more accurate view of what is
going on in medical encounters. In this sense, the concept of patient-centeredness should be understood as dynamic and variable according to the cultural contexts in which medical interaction occurs. That is, defining what it means to be patient-centered should go hand in hand with understanding cultural differences with regard to how providers and patients accomplish activities in interaction. The detailed interactional practices identified in this dissertation can be used as resources for discussing ways in which practitioners in Korea can refine what they do and developing better practices for improved patient care.

Implications for CA Research

In addition to exploring interactional features that are specific to a particular specialty and cultural context, this dissertation has also explicated a number of generic features of social interaction. The analysis of the complex coordination of activities in dental consultations advances our understanding of how multiple tasks and activities are managed in interaction. We saw in Chapter 5 how the dentist readies himself for the upcoming examination and treatment (e.g., putting on a face shield) while discussing dental problems with the patient. Furthermore, dental professionals perform collaborative work while engaging with patients, producing their actions with sensitivity to both their collaboration and the presence of patients (see Hindmarsh & Pilnick, 2002). In particular, participants rely on multimodal resources (e.g., speech, gaze, object manipulation) to manage more than one activity at a time. The dentist and the nurse, for instance, prepare tools and objects (e.g., dental mirror, face drape) while talking to the patient at the same time, engaging in ‘multiactivity’. The findings therefore improve our understanding of how participants mobilize different multimodal resources to coordinate multiple activities simultaneously.
In addition, the findings of Chapter 6 expand our understanding of the preference organization of initiating actions – which has been relatively understudied compared to research on the preference organization of responding actions. Importantly, the ‘delay’ of the delivery of negative oral hygiene evaluation is significant in that it is not just the delay of the turn in a sequence but that of the ‘bad’ news until after the dental examination and treatment altogether. That is, the dentist postpones the discussion of the oral hygiene results until when the patient comes out to the lobby area after dental procedures are done in the treatment room. This may be because the discussion of oral hygiene results requires changes in the spatial configuration of participants – in a way that is more appropriate for the activity of conversation rather than that of dental treatment. Especially because the dentist needs visual aids (i.e., intraoral photos) to show the oral hygiene problem to patients, he postpones the discussion of it until later when patients are in a more suitable position to see the intraoral photos. These findings indicate that the extent to which dispreferred actions are delayed can vary significantly depending on specific tasks and goals.

**Limitations**

The limitations of this dissertation have to do with some limitations of the collected data. First, the data for this dissertation include one clinic and one dentist. The data are therefore not representative of dental clinics across South Korea, and thus the generalizability of the findings within the Korean dentistry context remains to be further explored. Second, no recordings were made of the nurse-patient interaction before and after the dentist-nurse-patient encounter in the treatment room. For instance, interactions that involve the nurse taking the patient into the treatment room and helping him/her
prepare for the consultation or scheduling patient appointments in the waiting area before the patient leaves the clinic were not recorded. Further research is needed to investigate ways in which nurses and patients prepare for the business phase of the visit or negotiate the closure of the visit. Despite these limitations, this dissertation offers a detailed analysis of the organization of dental visits in the Korean context, providing a useful starting point for further research.

**Future Directions**

By analyzing interaction between dentist, nurses, and patients in one particular previously unexamined kind of cultural and specialty setting, i.e. Korean dental visits, this dissertation suggests that there is still much work to be done. First, future conversation analytic research can examine additional interactional practices involved in dental consultations. The findings presented in this dissertation reveal some distinctive features of dental consultations, such as the interactional complexities associated with the triadic nature of dental encounters or the moral issues involved in discussing patients’ oral hygiene. Future work could explore these issues further by, for instance, investigating how dentists and nurses collaborate and communicate during the examination and treatment phases or how dental practitioners provide instructions on patients’ self-care practices.

Second, further research is needed to examine Korean medical interaction to see if the culture-specific features described in this dissertation hold true in other healthcare settings. This dissertation confirms previous findings that provider-patient interaction in Korea tends to proceed ‘rapidly’ with an orientation to expeditious progression of task activities (Y. Park, 2013, 2017). Research in Korean medicine has indeed pointed out
short consultation time as a factor that lowers the quality of health care in Korea (e.g., Shin et al., 2011; Sohn et al., 2019). Further conversation analytic work can contribute to the discovery of detailed interactional practices specific to Korean medical encounters and the development of better practices for improved health services.
Appendix A: Transcription Conventions

[ ] Simultaneous or overlapping speech

= No gap of silence between utterances

(0.5) Timed silences in seconds

(.) Micropause

. Falling intonation

, Continuing intonation

? Rising intonation

:: Prolongation or stretching of the sound

- Cut-off sound

_word_ Stressed sound

° Quieter than surrounding talk

↑↓ Markedly higher/lower pitch

>fast< Quicker speech

<slow> Slowed speech

.hh Hearable inhalation

hh Hearable exhalation

(word) Uncertain hearing

( ) Undistinguishable hearing

((( )) Transcriber’s comments
Appendix B: Conventions for Multimodal Transcription

*  *  Gestures and descriptions of embodied actions are delimited between two identical symbols and are synchronized with corresponding stretches of talk.

*->  The action described continues across subsequent lines.

*->>>  The action described continues until and after extract’s end.

->*  The action described continues until the same symbol is reached.
### Appendix C: Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accusative</td>
<td>ATTR</td>
<td>Attributive</td>
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<td>CIRCUM</td>
<td>Circumstantial</td>
<td>COMM</td>
<td>Committal</td>
</tr>
<tr>
<td>COMP</td>
<td>Complementizer</td>
<td>COND</td>
<td>Conditional</td>
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<td>CONN</td>
<td>Connective</td>
<td>CORREL</td>
<td>Correlative</td>
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<td>CP</td>
<td>Copula</td>
<td>DCT.RE</td>
<td>Deductive Reasoning</td>
</tr>
<tr>
<td>DECL</td>
<td>Declarative</td>
<td>DEF</td>
<td>Deferential</td>
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<tr>
<td>DET</td>
<td>Determinative</td>
<td>DM</td>
<td>Discourse Marker</td>
</tr>
<tr>
<td>FR</td>
<td>Factual Realization</td>
<td>GEN</td>
<td>Genitive suffix</td>
</tr>
<tr>
<td>HON</td>
<td>Honorific</td>
<td>IE</td>
<td>Informal Ending</td>
</tr>
<tr>
<td>INT</td>
<td>Intentional</td>
<td>INTERR</td>
<td>Interrogative</td>
</tr>
<tr>
<td>LOC</td>
<td>Locative</td>
<td>NCOMM</td>
<td>Non-Commutative</td>
</tr>
<tr>
<td>NECESS</td>
<td>Necessitative</td>
<td>NEG</td>
<td>Negative</td>
</tr>
<tr>
<td>NOM</td>
<td>Nominative</td>
<td>PAST</td>
<td>Past suffix</td>
</tr>
<tr>
<td>POL</td>
<td>Polite suffix</td>
<td>PRECED</td>
<td>Precedence</td>
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<tr>
<td>PROP</td>
<td>Propositive</td>
<td>PT</td>
<td>Particle</td>
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<tr>
<td>PURP</td>
<td>Purposive</td>
<td>RESUL</td>
<td>Resultative</td>
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<tr>
<td>RETROS</td>
<td>Retrospective</td>
<td>TEMP</td>
<td>Temporal particle</td>
</tr>
<tr>
<td>TOP</td>
<td>Topic</td>
<td>TRANS</td>
<td>Transferentive</td>
</tr>
<tr>
<td>UNASSIM</td>
<td>Unassimilated</td>
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