

Orientations to Epistemics and Deontics in Treatment Discussions

Anna Lindström¹ and Ann Weatherall²

¹Uppsala University, Sweden

²Victoria University of Wellington, New Zealand.

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Address for correspondence:

Anna Lindström

Department of Linguistics and Philology

Uppsala University

Box 635

751 26 UPPSALA SWEDEN

anna.lindstrom@lingfil.uu.se

+46(0)18 4717007

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Abstract

An ideological shift to patient-centered health care raises questions about how, in the face of medical authority, patients can assert agency in interactions with doctors. This study uses conversation analysis to explore how epistemic and deontic orientations are raised and made relevant in different types of responses to treatment proposals across two health care settings – New Zealand general practice consultations and Swedish hospital-based physician encounters. By examining responses ranging from acceptance to strong resistance, we show patient practices for deferring to and resisting medical authority, which includes claiming independent access to expert knowledge and raising everyday, experientially-based concerns. Doctors rightfully privilege their own epistemic expertise in treatment decisions but they also take patient experiences into consideration. In cases of strong resistance we found doctors raising patients' ultimate right to refuse treatment recommendation. Our analysis further nuances current knowledge by documenting the ways epistemic and deontic domains are observably relevant forces shaping the sequential unfolding of treatment proposals.

Orientations to Epistemics and Deontics in Treatment Discussions

In ancient times, the Hippocratic Oath was introduced to ensure that medicine was practiced honestly and with the patient's well-being in mind (von Staden 1996). Adherence to the oath requires physicians to base treatment recommendations on scientific evidence. Failure to do so constitutes a breach of the Hippocratic Oath and may lead to accusations of malpractice (Nutton 2004). This is an incentive for physicians to make explicit the medical reasoning for proposing a particular treatment. Epistemics thus provides an ethical foundation for recommending treatment. In line with the discussion in the introduction to this volume, we use the term epistemics to refer to "the knowledge claims that interactants assert, contest, and defend in and through turns-at-talk and sequences of interaction" (Heritage 2013: 370).

In more recent times, the patient has been afforded an increasingly active role in the medical visit and in many countries around the world today, patient-centeredness is considered another important quality in health care delivery (Kaba & Sooriakumaran 2007; Stewart 2001). A patient-centered approach stipulates that the patient should be an active participant in his or her health care. Furthermore, patients should have the right to reject treatments even in cases where they are warranted on bio-medical grounds. Patients' deontic authority thus

underpins their rights to accept or reject treatments. Drawing on Searle's (1976) discussion of the two directions of fit between "the words" and "the world", Stevanovic and Peräkylä (2012) differentiate between epistemic and deontic authority in the following way: "epistemic authority is about getting the *words to match the world*, and deontic authority is about getting the *world to match the words*; epistemic authority is about *knowing* how the world 'is'; deontic authority is about *determining* how the world 'ought to be'." (p. 298). In this paper we explore joint decision making in medical visits by examining how interactants make the grounds for recommending a particular course of action or treatment available to one another (epistemics) and how the interactants decide on a particular course of action or treatment (deontics).

The tension between the bio-medical expertise of the physician and the personal experiences and preferences of the patient is a long-standing theme in research on clinical practice. The theme emerges in Mishler's (1984) microanalysis of the medical interview and is also at the core of research on medical paternalism (cf. Bremberg 2004). Within the medical interview, authority based on medical expertise is especially relevant in the parts of the encounter that involve diagnosis and recommendation of treatment. Peräkylä's (1998; 2002) research on the diagnostic phase of medical encounters, nuanced our understanding of medical authority by demonstrating that doctors go to some length to make the general basis of their diagnostic judgments available to patients. Peräkylä showed "that through the coordination of the design and placement of their diagnostic turns, the doctors treat themselves as accountable for the evidential basis of the diagnosis, thereby not claiming unconditional authority vis-a-vis the patients" (Peräkylä 2002: 221). The present study explores how bio-medical evidence is recruited (or disputed) in discussions regarding treatment and other courses of action.

The treatment stage of the medical encounter is characterized by a pressure for progressivity (Costello & Roberts 2001; Koenig 2008; 2011; Robinson 2003; Stivers 2005a; 2005b; 2005c; Stivers & Robinson 2006). Physicians will not move on to the next activity until they have secured acceptance from patients and the pursuit of acceptance can result in modifications of proposals for treatment. Prior research has shown that physicians orient to subtle shifts in reciprocity. While tokens like "okay" are treated as accepting, mere acknowledgments like "mm hm" and headnods are treated as manifestations of resistance (Koenig 2008, 2011; Stivers 2005b). Passive resistance thus provides a resource by which patients actively participate in how treatment recommendations emerge as acceptable (cf. Jefferson 1983). That patients can shape treatment recommendations by simply withholding talk highlights

that we must pay close attention to how silence is embedded within sequential contexts to capture joint decision making. Patients can also initiate actions that impact on treatment outcomes. Bergen and Stivers (2013) examined patient-initiated disclosures of medical misdeeds such as taking medication prescribed for someone else or failing to comply with life style recommendations. They found that by reporting these kinds of behaviors as transgressions, patients pay heed to the medical authority of doctors. In sum, previous research shows that medical authority and patient participation is embedded in the structural contingencies of turn and sequence (Robinson 2003).

Outside the medical context, the interactional research on decision making has documented its core interactional features. Lindström (1997; forthcoming) examined preferred responses to remote proposals in telephone conversations.¹ She found for yes no formatted remote proposals simple affirmation was treated as insufficiently aligning with the suggested course of action. Acceptance of a proposal was accomplished by affirmation plus a stance displaying commitment to the relevant course of action. In a study of workplace planning meetings, Stevanovic (2012; 2013) also found that more than agreement was needed to achieve a joint decision making about a future course of action. She showed that access to the content of the proposal, agreement and commitment to accomplishing it were necessary elements to a joint decision making process. Other outcomes to remote proposals were non-decisions and unilateral decisions. The features of the latter type of decisions in medical consultations include giving prominence to technical description over individual patient considerations (Collins, Drew, Watt & Entwistle 2005).

In this paper the sequential unfolding of decision making about treatment recommendations and other suggestions of courses of action are further detailed. A specific focus is on how epistemic and deontic orientations are made relevant in the proposals doctors make and the patients' responses to them. Our analysis aims at providing a better understanding of decision making dynamics in medical interactions by identifying the complex relationships between epistemic and deontic reasoning in treatment proposals and suggestions for other courses of action.

Data

Previous research on treatment recommendations has focused on data corpora from uniform clinical settings such as primary care, pediatrics, or oncology. Our research by contrast, mixes data from two different national contexts and includes routine and acute primary care as well as specialized hospital care. Furthermore, two different languages are represented in our materials. The New Zealand English general practice data are drawn from the Applied Research on Communication Health Group (ARCH) Corpus of health interactions at the University of Otago, Wellington, New Zealand.² From the larger ARCH corpus a subset of 14 complete, video-recorded, primary-care consultations were examined in detail for this study. The consultations ranged in length from lasting between 15 and 35 minutes and were selected because the patients were aged 65 years or older.

The Swedish data are drawn from the Swedish television documentary *Sjukhuset* [The hospital].³ This documentary series was recorded at two university hospitals between 2007 and 2012 and it depicts clinicians and patients in a variety of situations ranging from heart surgery to consultations regarding minor conditions, as well as mundane events in the everyday life on a hospital ward. As part of a pilot study, the first author has built a documentary care corpus of 239 transcribed segments of older persons' interactions with health care professionals in *Sjukhuset*.⁴ There is a long tradition in conversation analysis of turning recordings that were produced for other purposes than research into data (Mondada 2013). Nonetheless, it should be underscored that these films are produced to educate and entertain a television audience.⁵ The editing of scenes and the use of voice-overs limit access to the way interaction unfolds.⁶ We have therefore focused our analysis on segments without editorial cuts or voice-overs.

For this paper we use eight excerpts from different consultations to present our results. They represent the range of responses to treatment proposals and proposals for other courses of action in our larger collection and they were selected for their clarity and conciseness. The analysis is validated by the transcribed talk alone but where it is enhanced by additional description of visible action such as gesture and body position that is provided by comments enclosed in double brackets. The Swedish transcripts include literal and idiomatic translations to English (presented in succeeding lines). Person and place names have been changed in all transcripts. The implications of the older age of the patients for the findings will be a matter considered in the discussion.

Analysis

The extracts presented below show the full spectrum of response types we observed in our collection. They range from acceptance by acquiescence to doctor's authority to stark rejection of the treatment offered on the basis of patient's own medical expertise. Decision making dynamics are differently played out in each extract. In the first two extracts, patients relinquish their deontic rights by deferring to the doctor's authority. The second set of two extracts are also where the treatment proposal is accepted by the patient but deontic stance is more explicit in the agreements. A further pair of extracts provides examples of initial resistance to the treatment proposal. The final extracts show the strongest cases of non-acceptance we found which are also instances where the doctor explicitly raises the ultimate deontic authority of the patient to decide on treatments

Acceptance by acquiescing

The patient in excerpt (1) has a history of heart disease and was operated with mini maze surgery a few years earlier. He is seeking care at the emergency room due to auricular flutter. The problem started while the patient was on vacation and he drove directly to the emergency room from the airport. He is lying in the hospital bed and is hooked up to a heart monitor. The patient has been introduced to the cardiologist on call and we join the consultation as the cardiologist is explaining possible health outcome trajectories. The treatment proposal is to wait overnight in order to see whether medical intervention for the auricular flutter is actually necessary.

(1) HOSPITAL DISCHARGE DCCS (SJUKHUSET 20080204) .

- 19 DR: *Antingen* (.) är *dehä:r nåt som håller på å slår*
Either (.) is this any that keeps on n' beats
Either (.) this is something which is about to go
- 20 *om av sej själv; Eller så får man gö:ra en*
about of itself self Or so get one do one
back to normal by itself Or one will have to do an
- 21 *elkonvertering,* [pt .hh O:ch då tycker jag=
electrical cardioversion pt .hh And then think I
electrical cardioversion pt .hh And in that case I
- 22 PT: [Ja:visst,
Of course

- 23 DR: =inte de e mest lämpligt å göra de nu, .hh
not it is most appropriate n' do it now .hh
don't think it would be optimal to do it now .hh
- 24 Inatt, Utan då är de me:ra lämpligt att göra
Tonight But then is it more appropriate to do
Tonight Instead it would be more appropriate to do
- 25 de imorron, På- på morron eller förmi:ddan d[å,
it tomorrow On- on the morning or before noon then
it tomorrow In- in the morning or late morning then
- 26 PT: [Åkej,
Okay
- PT ((big smile))
- 27 DR: Eh har du nån följeslagare [me dej ell(er)
EH have you any companion with you or
Eh Do you have a companion with you to the hospital or
- 28 PT: [A: frugan är ju me
Yeah the wife is ju with
Yeah the wife is along
- 29 såklart åh [så hon ska ju hem då å
of course and so she will ju home then and
of course and so she is going home then and
- 30 DR: [A: [Va säger du: om
Yeah What say you about
Yeah What do you say about
- 31 PT: tvätta kalsonger nu hon v(h) [et(h)tu heh heh
wash the briefs now she you know
wash the briefs now you see
- 32 DR: [Ja,
Yeah
- 33 DR: Va säger du om den planen, Att- att du får
What say you about it the plan That- that you get
What do you think of that plan That- that you get
- 34 åka hem (.) å sova några timmar, Å sen kommer
go home (.) n' sleep some hours N' then come
to go home (.) and sleep for a few hours And then you
- 35 du tillbaks imorron bi:tti,
you back tomorrow morning
come back tomorrow morning
- 36 PT: ->Jo ja gör alltid som ja blir tillsagd [vettu,
Yes I do always like I am told know you
Well I always do what I'm told you know
- 37 DR: [Ja (hh),
Yes (hh)
Right (hh)
- 38 DR: .hh

39 PT: *De [e man ju så van sen he:mma va heh heh heh*
It is one ju so used to since home what
One is so used to that from home you know

The treatment proposal concerns the timing of a possible intervention (lines 21–25). The first part is a negative declarative “I don’t think it would be optimal to do it now” followed by a positive proposal for its delay “it would be more appropriate to do it tomorrow”. The patient responds with “okay” (line 26). Having secured the patient's access to the proposal that treatment be deferred, the cardiologist goes on to inquire whether the patient was accompanied by someone to the hospital. By using the gender neutral and distant reference "companion", he avoids making assumptions about the social circumstances and sexual preferences of the patient (Kitzinger 2005). The sensitive formulation of this question is in stark contrast with the patient's response where he formulates "the wife" as the self-evident person to accompany him to the hospital. His subsequent telling that the wife will go home to do his laundry (washing briefs rather than panties) is offered as a laughable but also has a serious note in displaying that the proposal to defer treatment is unproblematic for the spouse as well as she is eager to return home. The cardiologist disregards the joke and shifts the focus back to the treatment discussion by specifying the terms of the proposal (i.e. that the patient goes home and returns the next day). He pursues alignment from the patient (line 33). That the cardiologist does not treat the patient's initial response to the proposal (line 26) as fullfledged alignment is in line with findings from previous research on remote proposals and joint decision making (Lindström 1997; forthcoming; Stevanovic 2012). Furthermore this has been identified as a practice associated with a bilateral or more patient centered approach to medical decision making (Collins, Drew, Watt & Entwistle 2005) and as such it displays an orientation to the patients’ deontic rights. The patient accepts the proposal by saying that he always does as told – an acceptance that acquiesces to the doctor’s deontic authority. In line

39, the patient elaborates the grounds for acceptance by making a joke along gender lines (implying that he is used to his spouse bossing him around at home). The invocation of this membership category foregrounds the deontic aspect of the doctor-patient relationship.

Deferring to the doctor's deontic authority is also shown in the next case. In excerpt (2) the patient has just informed the doctor that he will be due for a repeat prescription on his medication at the end of the month. The doctor unilaterally (Collins et al 2005) proposes the patient get a blood test so that on a return visit he can get both the required prescription and the results of the test. The patient makes relevant the doctor's right to determine the treatment plan by referring to her as "the boss".

(2) RETURN VISIT ARCH TSGP1201

444 DR: get this blood test, (.) before that
445 and come (.) come and see me end of
446 the [month] so .hh has got another (.) couple of=
447 PT: [yeah]
448 weeks ther:e[and its] good to catch
449 PT: [yeah]
450 DR: up then anyway just to see
451 how things [going?]
452 PT: [yeah]
453 PT: oh yeah okay
454 DR: alright?
455 PT: yeah.
456 (2.0)
457 PT: ->you're the boss
458 (.)
459 PT: anything you say
460 .hh [ugm ugm]
461 DR: [just things] hasn't been y'know stable
462 like (.) so we just (.) need to keep an eye
463 on things a little bit more

The return visit is justified by the doctor as a recommended course of action on two grounds – getting a prescription and as an opportunity to assess the results of blood tests. The patient does not respond contiguously verbally or nonverbally to the unilateral proposal for blood tests. However, the patient does receipt with a series of “yeahs”, in overlap with doctor, the information relevant to the concern he raised about needing more medication in the near future (lines 447 and 449) and the doctor's explanation of the assessment aspect of the return

visit (line 452). Those receipts and the patient's fuller display of alignment in his turn "oh yeah okay" is not treated by the doctor as sufficiently aligning with the proposal because she pursues and receives confirmation of the patients agreement at lines 454-455.

It is after the doctor's pursuit of the patient's agreement, and perhaps because of it, that he characterizes her as a boss. That categorization invokes a standard relational pair (Sacks 1974) that maps himself as the subordinate member in the relationship. The categorization of the doctor as a superior boss and himself as their underling highlights her deontic authority to dictate courses of action. Directing and complying are activities that are inferentially bound to the boss-underling pair, which is made explicit when the patient adds "anything you say" (line 459). Here we thus have another example of a membership categorization device foregrounding the deontic aspect of the doctor-patient relationship by highlighting power and authority.

The next case also shows acceptance of a treatment proposals. However, the acceptance shows that agreement is on the basis of the doctor's medical expertise, not simply their deontic authority as in the previous two cases. The interaction is from a routine consultation with a 79 year old patient after the physical examination has been completed.

(3) MEDICATION TO TREAT HYPERTENSION ARCH ISGP0409

```
170 DR: Tch .hh it's(0.4) the last, (.) [few]=
171 PT: [ mm]
172 DR: =readings of your blood pressure have been up
173 PT: mm
174 DR:-> a::nd (2.0) i think we should (.) add (.) a pill (.)
175 to your little [ collection ] of pi:l[ls:]
176 PT:-> [do you think so] [ go]od? good?
177 Yes?
178 (0.6)
179 PT: yes
```

In extract 3, the reason for the treatment proposal is explained "the last few readings of your blood pressure have been up", which has been previously established as a regular feature of diagnosis and treatment recommendations (Peräkylä 1998; 2002). That linking is accomplished above at line 174 with an *and*-prefaced treatment proposal. *And*-prefacing is a practice for linking together different but related sequences of action (Heritage & Sorjonen 1994). The form of the proposal itself is constituted from two different domains of reasoning. "I think" is an epistemic claim because a doctor's view rests on his right and responsibility to

expert medical knowledge. The deontic domain is invoked with “we should”. The desirable course of action will be a joint accomplishment – the doctor adding a pill and the patient accepting it to her collection of pills.

The patient’s acceptance of the proposal is immediate, which is a regular structural feature of aligning responses (Schegloff 2007). The interrogative form “do you think so” shows the patient’s acceptance is contingent on it being the doctor’s recommendation. The patient further displays her acceptance with the positive assessment of the proposal (“good good”) and her willingness to participate in its achievement (“yes yes”).

Soon after the previous extract the doctor takes the blood pressure reading a second time and gets a lower reading, which makes the problem less doctorable. Consequently, he revisits the treatment decision placing it in the patient’s deontic realm by asking if adding a further pill would be manageable:

(3b) MEDICATION TO TREAT HYPERTENSION ARCH TSGP0409

217 DR: um (0.4) hmm. (2.0) .tch hhhh (2.0) yes the blood
218 pressure i took it the second time was actually a
219 li- a bit better [um] tch tch] tch
220 PT: [was it] mm mm]
221 (4.0)
222 GP: how do you go: about (.) i- is it eas- i mean in terms
223 of taking pills. (1.0) if i add another pill is that
224 going to be
225 PT: ↑nono [no:]
226 GP: [it's]it's a manageable [thing?]
227 PT: [it's a]manageable?
228 GP: yeah=
229 PT: =mm=

The patient’s ‘no no no’ implicitly claims the doctor’s concern about her taking pills is one he needs not pursue (Stivers 2004). The doctor makes the patient’s stance explicit when he says “it’s a manageable thing?”. The patient’s repeat of the doctor’s turn confirms what she previously alluded to (Schegloff 1996) – she will be able to take another pill. In the above

case, the patient's deontic stance about pill taking is the crux of the treatment decision for the doctor.

In the next case the patient has sought treatment at the emergency room due to a small head wound from a fall in the shower. After the problem presentation, the patient has already hinted at the relevant treatment by proposing in jest that she was going to stitch up the wound on her own but realized that she was not able to do so. Closely thereafter, the physician announces that he will take a look at the wound and the physical examination continues as follows.

(4) STITCHES DCCS433t1314 [Sjukhuset, Season 4, Episode 33].

- DR [((presses edges of wound together))
 [
- 56 DR: *De va- (0.4) va ganska gli:p[ande,*
 It was-(0.4) was pretty gaping
 It's (0.4) is quite gaping
- 57 DR: *De va inte jättestort*
 It was not real big
- 58 *men d[u måste ju helt klart sy:s,*
 but you must ju completely clearly be stitched up
 but without a doubt you must be sewn
- 59 PT: *[Nä,*
 No
- 60 PT: *->De måste're j[a:, Ja: just de, .Ahh,*
 That must it yea Yes just it Yes.hh
 It must yeah Yes that's right Yes.hh
- 61 DR: *[Ja:,*
 Yes
- 62 PT: *->De förstå:r ja,*
 That understand I
 I understand that
- 63 DR: *De måste're,*
 It must it
 It has to
- 64 PT: *.J[ahh,*
 Yeshh

That stitches are the relevant treatment is already projected in the physician's nonverbal actions during the diagnostic phase when he presses the sides of the cut together as if to explore whether stitches would be an option. The ensuing verbal assessment of the cut,

glipande, suggests a small opening like a tear in a seam and thus also indexes stitches as the appropriate remedy. This is followed by a downgraded assessment "it was not real big." While the downgraded assessment might calm the patient, it runs the danger of making the subsequent proposal of stitches as the appropriate remedy sound over the top. The physician manages the incompatibility between the downgrade and the treatment proposal by initiating the latter with the disjunctive "but." The treatment proposal itself is offered in strong deontic terms "without a doubt you must be sewn." The epistemic particle *ju* formulates the proposal as jointly held by the patient and the doctor. The patient accepts the proposal in the next turn. The reformulation "it must yeah" formulates the acceptance as based on an independently formed deontic and epistemic stance (Stevanovic 2012; Heritage & Raymond 2012). The independent stance is undermined by the doctor who treats the first TCU of the patient's turn in line 60 as an other-initiated repair by confirming the need for treatment in line 61 with an emphatic yes. The epistemic and deontic positions are subsequently recalibrated when the patient formulates her acceptance as epistemically derived from the information provided by the doctor (line 62) and the doctor insists on his deontic right to prescribe treatment (line 63).

Excerpts (3), (3b) and (4) were further cases where the treatments were accepted. In contrast to extracts (1) and (2), the treatment decisions were achieved in ways that underscored the patients' deontic authority. The next cases are examples where the patients take a more active role on the treatment decision.

Negotiating treatment decision

The following three cases were chosen because they all show initial resistance to the proposals being responded to. In all cases the resistance is mounted on experiential grounds, or from the lifeworld of the patient. The analysis shows the doctors' responding to the concerns raised, which in each case leads to patient acceptance of the terms of the initial proposals.

The first case is with a patient who has had a long history of reflux and is presenting again with that same problem. Prior to the excerpt below there has been a discussion about what foods might trigger an attack, how often the patient takes antacids and whether the symptoms have changed over time. The doctor has established the patient is suffering from frequent reflux attacks, which leads him to suggest a gastroscopy – a procedure the patient underwent some years prior. The patient provides only weak agreement to that suggestion, which

occasions further explanation from the doctor who follows up with further information about his reasons for suggesting the treatment.

(5) GASTROSCOPY REFERRAL ARCHISGP301

405 DR:-> so it's probably worthwhile with you being seventy two
406 now .h to think about having a repeat (.) look
407 down there .hh just to [see-]
408 PT: [mm] yeah i [suppose so yeah]
409 DR: [just just to see]=
410 DR: =what it's [doing.]
411 PT: [yeah] .tch mm .hh well might be a good idea
412 DR: i think [it probably would]
413 PT: [>i wanna last a little bit longer<] [heh heh heh]
414 DR: [sorry]
415 PT: I wou(h)ld li(h)ke- £I would like to l- stay on this
416 world [for a bit longer hah hah]
417 DR: [yeah well: the ahr-] the thuh what we're looking
418 for is a very very rare complication of [reflux and [i want
419 PT: [mm [mm
420 DR: to reassure you [that] it is very rare we=
421 PT: [okay]
422 DR: =want to make sure that there's not going to be any
423 changes in the cells [that could lead on to cancer].hh er
424 PT: [no that's (no good)]
425 DR: [which is highly unlikely]
426 PT: [er the o-]the o- the only thing what
427 i don't like it when they put that (.) the thing (.)
428 go(h)ing down i(h)n in the £stomach
429 DR: where as they're better at it now
430 PT: are they?
431 DR: the equipments alot better [than it was sixteen years ago]=
432 PT: [it is- oh yeah but i]
433 DR: =[it's still unpleasant] i must say=
434 PT: [last time (used it)]
435 DR: =[so it's not- it's not- a picnic]
436 PT: [yeah i know it- it- it is] unpleasant yeah
437 DR: yeah

The so-prefaced treatment proposal (lines 405-407) presents it as an upshot of the diagnostic reasoning (Robinson 2003: 43), which occurred just prior (not shown in the transcript). In this case, the medical authority in the proposal is passively formulated and its authority is hedged - 'it's probably worthwhile...to think about having'. Further justification for the proposal - the patient's age - is delivered as a parenthetical form.

The treatment proposal is possibly complete in line 407 at "repeat look down there". After that possible completion, there is a short silence, which indicates patient resistance to the proposal (Koenig 2011). The doctor continues his turn by adding an increment, explaining that the proposed procedure is 'just to see'. The addition of 'just to see' construes what is being proposed as something routine and nothing for the patient to be worried about. The

'just' in "just to see" also shows another available inference namely that a discovery of something more serious is actually possible. The unlikely but more serious result of the medical procedure it is may find "changes to the cells that could lead to cancer" (line 423).

The delay in the patient's response to the proposal is one indication of his resistance to it. Another is his repeated but weak agreement at line 408 – "yeah I suppose so yeah" and "well might be a good idea". The patient's ambivalence is evidenced by his concern about the potentially fatal consequence – that is, death - if he doesn't comply with medical authority (see lines 413 and 415 to 416). The doctor responds to the patient's concern about the potential for dying by offering reassurance, grounded in medical expertise that the treatment being proposed is to rule out a "very very rare complication of reflux" (also see line 420 and 425). The doctor's offer of reassurance regarding the unlikely event of finding cancer is received by the patient with an explanation of his dislike of the proposed procedure. A lifeworld concern that is accepted by the doctor who now shifts the grounds for reassurance from medical expertise into the experimental realm – "whereas they're a lot better at it now" (also see line 431). He also affiliates with the patient's experientially based stance, conceding that "it's still unpleasant".

So in excerpt (5) the doctor's reassurance is first designed to meet a lack of medical expertise about the chances of a bad outcome thus prioritizing medical authority in the treatment decision. The doctor's initial strategy in this excerpt is in line with the patterns we describe later as being typical in the face of patient resistance to treatment proposals. However, in the above case the focus on medical facts was misplaced with respect to the patient's perspective because his weak deontic stance to the treatment was actually grounded in concerns having to do with lifeworld concerns not a lack of access to the medical reasoning behind the proposal

In the next extract the patient has come to the doctor for a list of her prescriptions because she is going on an overseas trip. There has been a discussion about the medications and the doctor makes a no-change recommendation. The patient queries that proposal on the basis current medication is causing severe itching.

(6) CHANGE TO MEDICATION ARCH ISGP0501

```
150 DR:-> tch so .hh i certainly wouldn't want to
151      cha:nge medication before you went over[seas]
152 PT:      [ no ]
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153 (0.4)
154 PT:-> d'y'think i just still carry on with them even though
155 i'm scratching my(h)self to de(h)a(h)th hh
156 DR: .HHH that's ftri(h)cky hh .hh um ((leans back and folds hands))
157 PT: it's my scalp, (.) [particul]arly and the small=
158 DR: [mmm]
159 PT: =of my back, seems to be the worst areas
160 (0.4)
161 DR: hgm
162 (2.0)
163 DR:-> >of course it's not me that's scratching.< but .hh
164 (0.4) I would actually say ye(h)s heh
165 PT: what [come off-]
166 DR: [i would ac-] no i would say keep up with
167 them [while you were away]
168 PT: [yeah yeah okay]
169 DR: .hh because (.) er for- especially an overseas trip
170 it's not like you're [just]
171 PT: [yeah]
172 DR: =going to Sydney for a couple [weeks]
173 PT: [yeah]
174 DR: .hh I really wouldn't want to make any
175 changes [with your health care]
176 PT: [yeah yeah]
177 PT:-> well i've put up with it for years
178 DR: yeah
179 PT: i can put up with it for another three weeks
180 DR: mm
181 PT: yeah

The treatment proposal in the above extract is for no-change to the current medications. Its form has comparatively strong epistemic and deontic elements “ I certainly wouldn’t want to change”. The patient receipts the information rather minimally with “no” which displays little commitment to the proposal. The delay (line 153) adumbrates non-alignment, which is realised in a request for the doctor to reconsider her recommendation.

The request for reconsideration takes the form of a personal disclosure of a misdeed, which Bergen and Stivers (2013) documented as one practice that shows patient agency in medical decision making. In this specific case the patient reveals she is scratching herself to death, which is also an experiential description of a response to itching, which is medically ill-advised. Its extreme formulation justifies its legitimacy as a health concern. The laughter particles interpolated into ‘myself’ and ‘death’ modulates it as a transgression. Interpolated particles of aspiration regularly mark trouble or modulate the action of a particular formulation (Potter & Hepburn 2010). The doctor accepts the scratching as a difficult matter that requires consideration. She also affiliates with the patient’s stance by smiling, which can be seen on the video, and laughing that is marked in the transcript as smiley voice and laughter particles in and after the word “tricky”.

The ‘um’ at the end of the doctor’s turn in line 156 is a verbal display of cognition and her change in body position (leaning back) and gesture (hand folding) visual evidence that she is doing considering the matter. The doctor delivers the outcome of her consideration in lines 163-164, which upholds her original proposal. The delay in its delivery (lines 160-162) and its elaborate features shows it is a dispreferred response with respect to outcome of the reconsideration. Schegloff (2007) identified anticipatory accounts as a regular feature of dispreferred responses, which is shown in this case where doctor prefaces the result of her deliberation by disclaiming the sufficiency of her own lifeworld experience– “of course it’s not me doing the scratching but”. The affirmation to the carry on with the medication is more than minimal – “I would actually say yes”. The ‘actually’ marks the affirmation as counter to what might otherwise be expected if it was she who was doing the scratching.

The elaborateness of the doctor’s response to the reconsideration causes a trouble in understanding, which is resolved in a clear statement at lines 174-175 where the doctor reiterates her treatment proposal in the basis of medical expertise and authority “I really wouldn’t want to make any changes”. The ‘really’ and the ‘any’ are upgrades on the first version of the proposal at line 150 and strengthen its deontic stance. From line 177 the patient accepts the treatment proposal albeit as a compromise – she can put up with the scratching for another couple of weeks until she comes back from holiday.

Resistance on medical grounds

The previous two excerpts showed patient’s responding to treatment proposals with minimal agreement and commitment, which displays a weak deontic stance towards a joint decision on the suggested course of action (Lindström forthcoming; Stevanovic 2012). In both cases the doctor provided further explanation for their recommendation, which was subsequently accepted by the patient. The next two excerpts are the clearest and strongest cases of resistance to proposals from our collection. In both cases the initial objections were made on medical grounds. The doctors not only offer further medical grounds in support of the proposed treatment but they also explicitly raise the patient’s deontic authority to decline medically advisable treatments.

Excerpt (7) shows a proposal to treat on-going hypertension and the patient’s opposition to it which in turn engenders further explanation of the recommendation. Close to the beginning of

the additional explanation the doctor makes a parenthetical clarification that acknowledges the patient's ultimate right to decline the treatment.

(7) MEDICATION TO TREAT HYPERTENSION ARCH TSGP1501

171 DR: right (.) so just looking over (3.0) the past your- your
172 blood pressure has been high for (.) for quite a while
173 now
174 (0.2)
175 DR: .hh and i think it would be a good thing to >treat it<
176 (1.6)
177 DR: what we would normally er give you is a little water
178 tablet
179 (0.2)
180 PT:-> that's not the ones you gotta go on for life
181 (0.4)
. .
. ((24 lines of transcript omitted where doctor asks about
. the patients concerns))
. .
205 DR: Mmm. .hh i- i'll just explain to you what i'm thinking
206 ->and i mean (0.2) it's up to you in the end i'm not gonna
207 ->force you to do anything it's your decision .hh um
208 tch when the blood pressure's high (.) your heart has to
209 work harder?
210 PT: mm
211 DR: tch so- you have an increased risk of getting heart
212 attacks .hh and also (.) of stro::kes (.) when there's a
213 high pressure system °even in- if you think of the sink
214 or in in uhm° in a pump (0.2) it can burst more easily?
215 (0.2)
216 DR: so a high blood pressure is is a risk factor for stroke.
217 (1.0)

The *and*-prefaced turn at line 175 links the diagnostic reason – ongoing high-blood pressure readings - to the doctor's recommendation. The proposal is expressed as personal opinion of what is desirable “I think it would be a good idea to treat it” and as based in the collective practice of medicine the recommended course of action “what we would normally do”. The constitution of the treatment clearly rests, for the doctor, on the inextricability of her medical knowledge and the authority it affords to provide treatments. The long silence (line 176) is a slot where the patient could make some response to the proposal to treat the problem. It adumbrates non-alignment with the proposal.

The doctor provides further information about the treatment itself “give you a little water tablet”, which is minimized and formulated in lay rather than professional terms - “give” versus prescribe and “a water-tablet” rather than a more technical description of the drug. Word-selection is an established practice for building intersubjectivity between professionals and their clients (Kitzinger & Mandelbaum 2013; cf Koenig 2008; 2011). The non-medical

terms used in the formulation of this treatment are designed for a recipient with little expert knowledge.

The delay in the patient's response to the detail about the treatment proposal is a second indication of non-alignment structural characteristic of dispreference (Schegloff 2007). The form of the response is declarative and a negative observation - - "that's not the ones you gotta go on for life". Its form and content, after a delay, makes it starkly oppositional. The objection is based on some medical expertise the patient has - that the medication being proposed manages but does not actually cure high blood pressure.

At line 205 the doctor projects further justification of the treatment. The "just" in the preliminary announcement "I'll just explain to you what I'm thinking" orients to the availability of an alternative sense of her action and functions as an extreme case formulation (Pomerantz 1986). It defends against the attribution that the doctor is doing something other than explain the reason for her views. The action that is being disclaimed is pressurising or coercing. The doctor is showing her understanding that her explanation, after an objection to a proposal, is at risk of being interpreted negatively.

Following the preliminary announcement is not the anticipated explanation of the doctor's thinking. Instead, exploiting the next turn she has secured, the doctor makes a disclaimer. She is informing not pressurising or coercing the patient - "I'm not going to force you". The formulations used in the disclaimer "it's up to you in the end", "I'm not going to force you" and "it's your decision" are idiomatic and as such they invoke and constitute taken-for-granted knowledge (Drew & Holt 1988). What is invoked is the fundamental patient right to reject treatment proposals regardless of the scientific evidence that undergird such proposals. The doctor is thus showing that in the last instance, patients have the ultimate right to reject medical expertise and authority.

After the excerpt showed above the doctor goes on to further explain the medical reasoning behind the treatment proposal including that the patient is slim and eats well, which rules out lifestyle changes. The patient responds minimally or not all to that further explanation. In the face of such resistance doctor's regularly revise their treatment proposals (Koenig 2011; Stivers 2005b), which is also what happens in this case. Ultimately, the doctor offers a

revised proposal which is a blood test for diabetes because a positive test would provide further medical support of the desirability of prescribing blood pressure medication

An explicit mention to the patient's deontic authority to reject treatment is also shown in excerpt (8) which is drawn from a hospital consultation between a heart surgeon and a woman who has recently suffered a heart attack. The action that is being recommended is an x-ray examination of the coronary vessels. The consultation begins with the physician referencing a third party (another physician) as telling him that the patient is opposed to the x-ray examination. He then pursues the reason for the patient's opposition by asking whether she is afraid of him. The patient dismisses this and proposes that "we try to heal this in some other way". The excerpt below comes right after the physician has emphasized that failure to adhere with the treatment proposal would increase the risk of another heart attack.

(8) CORONARY STENT PRE-OPERATIVE CONSULTATION (Sjukhuset, Season 1, Episode 48) .

- 01 DR: *pt Min uppfattning ä: att de- att de e*
pt My opinion is that it- that it is
pt I am of the opinion that it- that it
- 02 *bra för dej,*
good for you
- 03 PT: *A,*
Yeah
- 04 DR: *Å vi kan gö:ra de:n undersökningen me*
N' we can do that examination with
And we can do that examination with
- 05 *ganska liten risk,*
quite small risk
quite little risk
- 06 P: *A,*
Yeah
- 07 DR: *->.hh Men känner du att du inte vill de*
.hh But feel you that you not want that
.hh But if you feel that you don't want to
- 08 *->så e're:- Så ska vi inte tvinga dej*
so is it- So will we not force you
then it's- Then we won't force you
- 09 *->(.) på nå [sätt,*
(.) on any way
(.) in any way
- 10 P: *[Nä: nä nä,*
No No no

In lines 1–2 the surgeon recommends the desirability of the treatment from his expert point of view thus underscoring his deontic authority. The emphasis on the possessive pronoun "my", marks the surgeon's position as contrastive with that of the patient. The recommendation is met with unmarked acknowledgment by the patient. Stivers (2005a; 2005b; 2005c; 2007) and Koenig (2011) showed that unmarked acknowledgment following a treatment recommendation can engender a revision of the treatment proposal. However, here the surgeon persists with the desirability of his original proposal by stating that the examination is low risk. The patient receipts this with another unmarked acknowledgment which causes the surgeon to back down from his persuasive tack. The turn-initial "but" links back to the surgeon's prior turn and emphasizes once again that the physician's and the patient's points of view are at heads with one another. The physician formulates the patient's stance as grounded in emotion and personal desire (line 7). This portrayal actually contrasts both with the patient's argumentation before this excerpt as well as her calm and confident composure throughout the sequence. The physician brings the treatment negotiation to a close by acquiescing to the patient's deontic right and authority with the negative formulation "we won't force you in any way". In contrast with the weak uptake in lines 3 and 6, the patient now responds forcefully with "no no no" resisting the physician's implication that she might be feeling coerced (Heinemann 2009; Stivers 2004).

The above two cases show doctors orient to their own and their patients' domains of authority. The doctors' authority to treat patients is grounded in medical expertise and in the above cases we see them making their biomedical reasoning available to patients. The patient's deontic authority is a right that exists independently of medical knowledge. Our analysis shows that this comes to a head when objections persist in the face of biomedical reasoning.

Discussion

A goal of this paper was to further explicate the interactional forces shaping the unfolding of treatment proposals and proposals for other courses of action. By examining different kinds of responses to recommendations across two distinctive health care settings we have shown a

dynamic interplay between epistemic and deontic orientations. Our findings add complexity to what has previously been treated as a directly oppositional relationship between the medical expertise of clinicians and the everyday experience of patients (Mishler 1984). They also complement the growing body of literature that documents patient agency in health care interactions (e.g., Bergen & Stivers 2013; Koenig 2011)

In the epistemic domain, we have confirmed that, from the doctors' perspective, medical expertise is foregrounded as the basis for their treatment recommendations, which is a fundamental principle of evidenced-based health care and the basis upon which patients seek health services. Patients' generally do have more limited access to medical expertise. Nevertheless, we found the patients did mobilise medical knowledge to resist treatment proposals. We have also observed that treatment resistance, grounded in the lifeworld of the participant is treated by doctors as legitimate, which is consistent with the spirit of the Hippocratic Oath. Thus our analysis importantly supports an emergent distinction between an epistemics of expertise and an epistemics of experience, with the latter being coordinated with the former in the sequential development of treatment recommendations (Weidner 2012; Heritage 2013).

In the deontic domain the doctors' stance – their right and obligation to recommend courses of treatment – is grounded in their epistemic authority as experts in medicine. However, the ultimate deontic authority resides with patients as they have the irrevocable right to refuse a treatment. We found physician's explicitly invoking that right in the face of patient resistance on medical grounds. That invocation was used to construe the provision of further medical reasoning as informing the patient rather than coercing them. In stark contrast to moments when doctors appealed to the deontic authority of the patient was when patients explicitly deferred to the deontic authority of the doctor. Those deferrals – “I always do what I'm told” and “you're the boss...anything you say” occurred in two different interactional environments – when the doctor was soliciting the patient's view about the proposal and also when they were not.

Our research is somewhat unusual being based on older patients across very different sorts of medical encounters. Older adults are a patient population construed as particularly vulnerable in support and care situations (Lloyd et al 2012). However, we suggest that the implications of our results are not limited to that population. All adult patients have the potential to

actively corroborate medical reasoning and to launch resistance to treatments on those grounds or on experiential ones. The diverse medical settings – across national contexts including routine, acute and specialized hospital care turned out to be a strength of this research because it affords stronger claims about the relevancies of epistemic and deontic domains in treatment proposals and responses to them.

Epistemic and deontic domains of reasoning are visible forces shaping treatment discussions and constituting doctor-patient interactions. Within the epistemic domain we have documented the interplay between medical expertise and personal experience in treatment decisions. The epistemics of expertise and the epistemics of experience are separate but related to the deontic domain of those same authorities – expertise and experience. Doctors have the right and responsibility to recommend treatments based on scientific evidence which also need to be fitted to the patient’s well-being. Patients have the right and responsibility to refuse proposals on the basis they understand the expert knowledge that grounds them. Epistemics and deontics are indeed complex and powerful structural forces scaffolding doctor-patient interactions and the ways treatments are recommended and responded to. On the basis of close consideration of those complex forces in practice we tentatively propose that patient-centered care involves the legitimation of life world-concerns without compromising medical expertise.

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¹ See also Houtkoop Steenstra (1987).

² The ARCH Corpus is a digital archive of video-recorded consultations and related data collected progressively since 2003 by members of the Applied Research on Communication in Health Group (ARCH) for a series of studies funded by the NZ Health Research Council, the NZ Marsden Fund, the NZ Lotteries Health Research Fund and University of Otago (URL: www.otago.ac.nz/wellington/research/arch/).

³ These recordings are available to the public at the Swedish Media Data Base of the National Library of Sweden.

⁴ As recordings in the public domain these data are available to research. We nonetheless choose to show respect to the patient's right to privacy by not including segments in our data base where the patient's face has been anonymised.

⁵ As compared to its United Kingdom counterpart, the Swedish version of this series seems to prioritize education over entertainment.

⁶ We are currently in the process of negotiating access to make recordings of naturally occurring clinical visits in primary care and hospital settings.