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► **To cite this version:**

Moa Hagafors. Changing treatments: Patient responses to doctors downgrading their medical authority. Språk i praktiken - i en föränderlig värld [Language in practice - in a changing world], ASLA, The Swedish Association of Applied Linguistics, Apr 2022, Stockholm, Sweden. 10.17045/sthlmuni.24321526.v1 . hal-04422620

HAL Id: hal-04422620

<https://hal.science/hal-04422620>

Submitted on 26 Mar 2024

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Changing treatments: Patient responses to doctors downgrading their medical authority

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Abstract

In conversation analytical research, doctors have been shown to formulate the different parts of the medical consultations, such as the treatment recommendation, in a way that more or less includes the patients in the process. Doctors' medical authority and patient agency are thus key notions to consider in the sequential unfolding of the decisions taken throughout the consultation. Aiming to study the patients' reception of doctors downgrading their authority in addressing possible treatment changes in Swedish and English medical interactions, the article shows that patients either align with the shared responsibility by accepting or resisting a treatment proposition, or disalign with it by orienting to the doctor's medical authority and refusing to claim patient agency. It is proposed that this difference is connected to the way doctors address the topic and the amount of authority they attribute to the patient. Propositions giving patients a moderate amount of responsibility seem preferable over open questions entailing a greater commitment, if one wishes to promote patient agency.

Introduction¹

Formulations of different parts of medical consultations have received considerable attention in conversation analysis. Peräkylä (1998) has shown how previous research (Byrne & Long [1976] 1984; Freidson 1970; Heath, 1992, cited in Peräkylä) suggests that doctors fully rely on their own authority and therefore do not need to “sell” or motivate their diagnosis to the patients. However, Peräkylä himself demonstrates how on the contrary doctors in more recent days do not always simply *state* their diagnosis, but tend to display the way in which they have acquired their knowledge by referring to for example their observations. In doing so, they present themselves as accountable and thus

counterbalance their medical authority, presenting the diagnostic process as no longer belonging exclusively to the medical domain but also being accessible to the patients. When it comes to treatment recommendations, Stivers et al. (2017; Stivers & Barnes, 2018) show that these can take the form of five different social actions, namely pronouncements, suggestions, proposals, offers and assertions². Several of these leave room for the patient to accept, resist or refuse. Stivers (2006) does indeed stress that treatment decisions are a matter of negotiation between physicians and patients, where the physicians rely on the patient's acceptance for the treatment recommendation to be established, which is in line with several studies that have underlined the important role and agency of patients in treatment decisions (Bergen et al., 2017; Costello & Roberts, 2001; Koenig, 2011; Stivers, 2002, 2005, 2006; Stokoe et al., 2020, etc.). Lindström and Weatherall (2015) more specifically illustrate that physicians and patients orient to their own and each other's deontic and epistemic authority when proposing treatments in the physicians' case, and accepting or refusing the propositions in the patients' case. They refer to Stevanovic and Peräkylä's (2012) distinction between deontic authority as being "about *determining* how the world 'ought to be'", and epistemic authority as being "about *knowing* how the world 'is'" (p. 298). As Lindström and Weatherall make clear, the patients' deontic authority is related to the fact that, with the current patient-centred approach, they are both expected to and have the right to actively participate in the treatment decision. Although medical interactions are typically seen as asymmetrical (Drew & Heritage, 1992; Mondada & Keel, 2017), partly due to the uneven distribution of knowledge between the participants, it would of course be a mistake to assume that the doctor detains all knowledge and the patient none. The physician does have a particular "professional vision", that is, "socially organized ways of seeing and understanding events that are answerable to the distinctive interests of a particular social group" (Goodwin, 2018, p. 408), in this case the medical corps, but as Heritage (2013) points out, both doctors and patients are knowing participants in the consultation: the doctor with their "epistemics of expertise", resulting from their training and professional practice, and the patient with their "epistemics of experience", relating to their experience of the condition and the different facets of living with it. In the different parts of the medical visit, one or the other may thus be of greater importance, and in deciding upon a new treatment, both the professional vision on the different options available and the layman's perception of past treatments come into play.

The question of authority is thus a complex matter that is sequentially negotiated in the medical visit. Participants may claim authority, for example by referring to their knowledge or clearly asserting what needs to be done, but they may also downgrade their authority in different ways. One strategy is to hedge, that is, to “reduce the force or truth of an utterance” (Kaltenböck et al., 2010), with, for example, approximators such as “sort of” and “a little bit”, or epistemic downgraders like “I think” and “possibly”. A participant may also use other techniques to attenuate what Heritage (2012, 2013) refers to as their *epistemic status*, defined as a speaker’s positioning on an epistemic gradient between more knowledgeable (K+) and less knowledgeable (K-). As Heritage shows, different formulations may result in different positionings of the speakers on this epistemic gradient. Saying “You are married” to someone creates a fairly levelled gradient, where, while the interlocutor has the first-hand information on the topic and therefore is more knowledgeable, both speakers apparently are informed on the subject. On the other hand, asking “Are you married?” creates a steeper gradient between the two speakers, where the interlocutor seemingly is significantly more knowledgeable than the person asking the question. Another form of question such as “You are married, aren’t you?” would create a gradient whose steepness would be somewhere in between that of the two other formulations. Not only hedges but also the structure of the turn may thus come into play in the claim or downgrading of a participant’s authority.

What is of interest in this article is patients’ reception of doctors downgrading their authority in these different ways when addressing a possible treatment change. Two key notions when looking at a participant’s reception of a turn are those of *alignment* and *affiliation*, which, according to Stivers et al.’s (2011) definition, respectively concern the participant’s cooperation on a structural and on an affective level. While an aligning response “match[es] the formal design preference of the [prior speaker’s] turn”, an affiliative response “match[es] the prior speaker’s evaluative stance”. Moreover, according to the same definition, an aligning response also “accept[s] the presuppositions and terms of the proposed action or activity” (p. 21), such as the distribution of authority between the participants. The aim of this paper is to study whether the patients align with the doctors’ reduced authority and claim authority of their own, or if they react in other ways. By analysing three examples with three different forms of patient responses, the hope is to contribute to a better understanding of how reduced medical authority relates to patient agency.

Data and methodology

The data consist of two corpora of medical interactions recorded in Sweden, in the first case, and England, in the second case. The Swedish one consists of nine video-recorded consultations, of a total of five hours, with patients who have or are suspected to have a rheumatic disease. The recordings were collected by Melander Marttala (1995) in three different contexts: registration visits at a rehabilitation clinic, referred first visits and follow-up visits. The doctors are in all cases either specialised in rheumatological diseases or under further training. The English corpus contains thirteen audio-recordings of a total of about 90 minutes, collected for the Audio British National Corpus (Audio BNC; Coleman et al., 2012), which all consist of consultations with a general practitioner. The conditions of the patients are of different natures (both physical and mental), and for several patients the doctor is their attending physician. Both the Swedish and the English recordings were transcribed within their respective projects, but in an attempt to homogenise the transcriptions of the extracts presented here and add more precision (especially in terms of overlaps, pauses and multimodality), I have re-transcribed them based on the transcription systems developed by Jefferson (2004) and Mondada (2018)³.

The Swedish consultations were recorded between 1989 and 1992, and the English ones in 1993, thus during the transition period towards the more patient-centred approach which has since then more generally been put into place. This surely means that there has been an evolution in medical practice since the time of the recordings, and that the results of this paper therefore are not completely generalisable to contemporary medical interactions. However, the choice of these fairly dated corpora is motivated by a wish to make use of already existing data, something which is at the core of the notion of open science. Also, the fact that the two corpora were constituted in approximately the same period of time increases the comparability between them, and I hope that these results can be used as a basis for future diachronic comparisons.

From the above-mentioned data, I built a collection of nine extracts fulfilling the following criteria: (1) the doctor (and not the patient) addresses the topic of a treatment change, and (2) they downgrade their authority in some way in addressing this treatment change. The notion of *treatment change* is understood in a broad sense and includes any action undertaken in the goal of improving or controlling the patient's condition. It may thus be a question of changing the type or dosage of a medication, or else referring the patient to another expert or

putting in place a lifestyle modification. The term *change* in itself is also used in a general sense according to the different patient profiles, and may include both the introduction of a new treatment for a first-time visitor, and a shift from one type of treatment to another for a more “experienced” patient. In most of the extracts, the topic of a treatment change is addressed in the form of a recommendation, but it can also appear as a more open question directed to the patient. Through conversation analysis of the different addresses and patient responses, it is possible to discern two main sequential patterns in the patients’ reception: an aligning one and a disaligning one, which will be developed in the analysis below.

Analysis

Downgrading one’s own authority in a conversation typically entails leaving room for the other(s) to take a more active part in the interaction. When this is done by a physician bringing up the topic of a treatment change, it opens up for the patient to have their say on the matter and express any possible preferences. Even though the simple fact of the patient aligning with this relative evening-out of authorities thus constitutes the preferred action, we will see that this does not necessarily correspond to an affiliation with the doctor’s suggestion, but that they can claim agency both in accepting and in resisting the proposition. The patient may also disalign with the doctor opening up for an agency claim and refuse to share authority in the treatment decision.

Alignment with the attributed authority

Aligning with the authority attributed by the doctor means accepting to, at least in part, share the responsibility of the treatment decision. In the following two examples, we will see how this responsibility is assumed to different extents and with different goals: to either accept a recommended treatment or resist its execution.

Accepting the treatment

In our first example (Extract 1), the patient chooses to agree with the doctor and accept the treatment. The consultation, taken from the Swedish corpus, is a first-time visit with a specialist by a patient suspected by her general practitioner to have rheumatism, but who is preliminarily diagnosed with arthrosis during her visit. After discussing different blood tests that need to be carried out, the doctor

introduces the question of a possible treatment with a bandage relieving the pressure on the patient's wrists:

Extract 1. LOP14 "artros" (22.45)

1 DOC o:ch eh sen kan vi väl, (0.4) höra med arbetsterapeuten om det
**and er then we can PTCL "RIGHT" (0.4) see with the occupational
therapist if there**
2 inte e nåt: eh bandage eller nånting du kan få .h att använda
isn't some er bandage or something that you can get .h to use
3 som avlastar. när du* har mera besvär
which relieves the pressure when you have more difficulties
pat *slight nod *
4 *(1.5) *
pat *deeper nod*

In suggesting that they check with the occupational therapist if the patient can get a bandage or something, the doctor opens up with several hesitation markers in line 1: an elongated *o:ch* ('and') and the filler *eh*, before suspending the actual proposal with a (0.4) pause. This is accompanied by the particle *väl* which both expresses an uncertainty about the entire verb phrase in which it is inserted and, in a way similar to the English tag question *right*, projects a confirmation from the patient. Not only is the patient included in the action that is to be proposed with the inclusive pronoun *vi* ('we') preceding the particle, but *väl* thus also establishes her as being a part of the decision-making and of the judgment of the do-ability of the action that is to be suggested. To relate back to Stivers et al.'s (2017) five social actions, it can be concluded that the doctor "specifically invites the endorsement or the collaboration of the patient" (p. 14), implying that this recommendation corresponds to a *proposal*, that is, a recommendation instigated by the physician where the decision-making is treated as being shared between the patient and the doctor. In pronouncing the actual proposal, to check with the occupational therapist if the patient can get a bandage or something similar (*höra med arbetsterapeuten om det inte e nåt: eh bandage eller nånting du kan få*, lines 1-2), the doctor once again shares her responsibility and expresses uncertainty. The accountability of the final decision is this time shifted to (and not as much shared with) the occupational therapist, to whom she attributes a certain epistemic and deontic authority in depicting her as being the one both capable of judging what would be the right aid to use (thus referring to her colleague's expertise), and of taking the final decision about the treatment choice. The expression of uncertainty here takes place on two different levels: neither is it sure whether there is an appropriate aid available for the patient (there is a need to 'check', *höra*), nor is it certain that a bandage is what the occupational therapist will

propose, which is signalled by the approximators modifying *bandage* (*nåt eh bandage eller nånting*, ‘some eh bandage or something’). Furthermore, this kind of alternative (*eller nånting*) also hedges the doctor’s proposal in a way that raises the odds of a confirmation on the behalf of the patient: an acceptance would not necessarily imply a commitment to use a bandage, but the patient can confirm and still choose to go with a different kind of support without “breaking her promise” or going against what was decided. Per se, a confirmation of the proposal does not even mean a commitment to use a support, but only an acceptance to consult the occupational therapist. Thanks to the vague formulation of the treatment proposal, the patient would thus not bind herself too much by confirming. It can also be noted that incrementally to this proposition, the doctor adds justifications of why and when such a bandage is useful (*att använda som avlastar. när du har mera besvär*, ‘to use which relieves the pressure when you have more difficulties’, lines 2-3), which is a way to share her professional vision with the patient and which is in line with Peräkylä’s (1998) findings of a tendency amongst doctors to include the patient in the thought process of the diagnostic procedure, even though it is in this case a question of a treatment decision.

Towards the end of the justification, the patient affiliates with the doctor by nodding slightly as the doctor pronounces *avlastar när du* (‘relieves the pressure when you’) in line 3. After the latter’s turn-constructural unit, the patient aligns with the demand for confirmation and accepts the doctor’s treatment proposal by a more pronounced nodding. In doing so, she also accepts the shared responsibility and authority attributed to her by the professional. Although the alignment is done in a fairly weak manner (being non-verbalised), the nodding constitutes the only response to the demand for confirmation having introduced the proposal (notably by *väl*) and acts as the second part of this adjacency pair.

Resisting the treatment

The second extract comes from another Swedish consultation, more precisely at the registration unit of a rehabilitation centre for rheumatic patients. The patient in question has suffered from rheumatic issues, mainly in the knees and in the wrists, for 17 years, and enrolls the centre for the third summer in a row. The doctor asks if she has already taken part in group treatments for the wrists and the patient answers that she has. However, she questions the need to work on the flexibility of these joints since she was in pain for months after doing so during her previous years at the clinic, and she thus presents a negative stance

towards the wrist treatments mentioned by the physician. After a question from the latter about whether she has already used supporting bandages, to which she answers no, the doctor disaffiliates with the patient's negative stance towards the wrist treatments in initiating her recommendation in Extract 2:

Extract 2. LOP10 "till vilket pris" (10.24)

- 1 DOC pt #eh::# då *kansk:#e#* vi i alla fall skulle b- (0.3) bestämma
pt er then maybe we would still d- (0.3) decide
- 2 att du får prata *igenom* de här lite grann med nån
that you get to talk through this a little bit with some
- 3 arbetsterapeut (0.2) å *titta* [på för att]
occupational therapist (0.2) and look at because
- 4 PAT [ja]
yeah
- 5 DOC de e många som har stöd å *#använda* ibland när man gör
there are many who have support to use sometimes when one does
- 6 *ansträngande saker#* (0.7) de de e ju så att- de e *bra* att ha en
strenuous things (0.7) it- it is PTCL "AS IS WELL KNOWN" like that
- 7 *rörlighet* (0.4) i handleden
flexibility (0.4) in the wrist
- 8 PAT ja jo jo visst jag är [fullt *med-* fullt *medveten*] om de men de&
yes yeah yeah sure I am fully aw- fully aware of that but it
- 9 DOC [men men (0.2) men inte]
but but (0.2) but not
- 10 PAT &e t- *till vilket pris *
is a- at what cost
- pat *shakes index finger towards doc*

The doctor proposes that the patient talk through the question of treating the wrists with an occupational therapist (lines 1-3). Like in Extract 1, there are a number of visible hesitation markers in the opening of this proposal in line 1, and there are hedges of both epistemic nature (*kansk:e*, 'maybe', and the conditional auxiliary *skulle*) and approximative nature (*lite grann*, 'a little bit', *nån*, 'some'). These downgrade the proposal which, as already mentioned, disaffiliates with the patient's expressed negative opinions towards the treatments that she has previously been assigned: even though she has had this negative experience and has never used supporting bandages, the doctor proposes a meeting that would possibly lead to her having to go with one or both of these options. The disaffiliative nature of this proposition is notably displayed by the concessive adverb *i alla fall* ('still'). Besides downgrading this proposition with hedges, the doctor also, like in Extract 1, includes the patient in the decision making with the pronoun *vi* ('we'), and shares the responsibility with the occupational therapist who would be the one to take the final decision about the treatment. However,

this sharing is not done in the same manner or with the same implication in the two extracts. When it comes to the inclusion of the patient, it can be noted that in Extract 1, the proposition is that ‘we’ check with the occupational therapist, whereas in Extract 2, it is that ‘we’ decide that the *patient* gets to talk with the occupational therapist. Consulting the expert colleague is thus a common action in the first case, and something which would ultimately be the patient’s responsibility in the second case. Also, given that the recommendation in Extract 2 is part of an argumentative sequence where the patient and the doctor express different opinions on the use of wrist treatments, the recourse to the judgement of a colleague can also be a way for the doctor to increase her authority.

The syntactic structure of the proposal reaches a possible completion at this point (line 3), but is expanded with a cut off *å titta på* (‘and look at’), which is left incomplete in favour of an explicative subordinator (*för att*, ‘because’). Just like in Extract 1, the speculative nature put in place by the epistemic hedges, as well as the inclusion of the patient in the decision making, signify that the recommendation corresponds to a *proposal* in the words of Stivers et al. (2017) and Stivers and Barnes (2018). As already noted, this recommendation form explicitly calls for an acceptance by the patient, and therefore the non-response at the first possible completion point in line 3 is treated as an absence of an acceptance. The expansion thus constitutes a continued pursuit for answer (Pomerantz, 1984). Part of its beginning (*på för att*, ‘at because’) is overlapped by a hesitant sounding *ja* (‘yeah’) on the behalf of the patient. The hesitancy of this affirmative answer is confirmed by the doctor not treating it as an acceptance but continuing to pursue an answer in explaining the use of supporting bandages in line 5. She starts off with an evidential claim that a lot of people use supporting bandages, which turns into a generality with the generic pronoun *man* (‘one’): *när man gör ansträngande saker* (‘when one does strenuous things’, lines 5-6). The doctor thus shares her professional vision and knowledge acquired from other patients with the current patient and includes her in her reasoning, while deploying the argument of patients frequently using these bandages as support for her argumentation. There is another possible completion point after this (line 6), and the lack of reaction by the patient is once again treated as an absence of an acceptance, or at least an absence of a comprehension of the utility of the treatment, which provokes another pursuit for an answer. The doctor presents general knowledge, that is, another form of an argument, about the utility of the mentioned treatments, saying that it is good to have a certain mobility in the wrist. In doing so, she explicitly appeals to common ground with the modal particle *ju*.

In one way, this particle presents the patient as knowing, affirming that she does have this information already, and, at the same time, it challenges the patient and expresses that she has “failed to take into account shared knowledge”, as has been demonstrated to be the case when *ju* is used in answers to questions in Swedish and Danish (Heinemann et al., 2011, p. 107). The possession of this knowledge is backed up by the patient herself (*ja jo jo visst jag är fullt med- fullt medveten om det*, ‘yes yeah yeah sure I am fully aw- fully aware of that’, line 8), and is incorporated into a ‘yes but’ construction resisting the proposition through a questioning of its well-foundedness: *men de e t- till vilket pris* (‘but it is a- at what cost’, line 10). This turn corresponds to one of the ‘yes but’ constructions put forward by Steensig and Asmuß (2015) in that it constitutes a disagreeing action after a suggestion with a clear preference for acceptance. The authors differentiate between what they call simple ‘yes but’ constructions which “innocently” update the previous speaker with new information and accordingly typically display no dispreference markers, and complex ‘yes but’ constructions which are more socially problematic and focus on a difference in points of view in addressing “a potentially morally problematic lack of knowledge, something which prior speaker ought to have known” (p. 358). The ‘yes but’ construction in Extract 2 clearly corresponds to the latter, and its conflictive nature is further underlined by the patient’s gesture: while pronouncing *till vilket pris* (‘at what cost’), she raises her index finger and agitates it toward the doctor in a correcting manner. Verbally and non-verbally, she challenges the rationality of the doctor’s thinking in reminding her of something that she has failed to keep in mind: although the patient’s wrists became more flexible after taking part in previous group treatments, they hurt for months afterwards. The patient thus orients to her expertise of experience, and there is an explicit clash between her point of view and the point of view of the doctor which is based on a professional vision and expertise.

We thus have another example of when the doctor downgrades her authority by presenting the recommendation as speculative, shifting the final decision to her expert colleague and inviting the patient to have her say in the matter. Although Extract 2 differs from Extract 1 in that the patient here clearly resists the proposal, they have in common the fact that the patients assume the shared responsibility put in place by the doctor by responding to her demand for confirmation and thus taking an active part in the treatment decision. This is, as we have seen, done at different strengths in the two extracts: whereas the patient in Extract 1 merely nods to express her acceptance, the patient in Extract 2 clearly

positions herself in the question both verbally and multimodally. This could possibly be explained by the difference in experience between the two patients. Patient 1 is a first-time visitor and has not yet received an official diagnosis. Patient 2, on the other hand, is an experienced patient who has not only suffered from rheumatism for 17 years, but is also situated in another context: she participates in the consultation as a part of a registration process at the rehabilitation centre where she has already tried several different treatments. It can thus be assumed that she knows more not only about what works for her and what is at stake, but also about how to behave in a medical consultation to get what she desires. The sequential context is also of great importance since Extract 2 follows an already started disagreement between the doctor and the patient, with which the resisting response is thus in line.

Disaligning with the attributed authority

Even though the majority of the examples from our collection constitutes recommendations where the patient accepts to share the responsibility of the treatment decision in the two ways we have seen above, there are also some cases where the doctor does not address the topic of a treatment change in the form of a recommendation but by pronouncing an open-ended question about the patient's preferences, and where the patient disaligns with the shared responsibility, as we shall see in the following example. In Extract 3, taken from the British corpus, the patient consults her general practitioner about the panic attacks for which she has been taking medication prescribed by the doctor in question for a certain period of time. She explains that she only takes them when she needs to, and not on a regular basis. After having recounted her recent experience, the doctor asks what she wants to do about the medication she is currently taking in Extract 3:

Extract 3. Eng-med-4 "panicky" (01.43)

```

1  DOC  what do you want to do about the:se. be[cause, ]
2  PAT                                     [↑WELL, ] (.)
3      [well what do you thi-]
4  DOC  [do you                               ] find they wo:rk
5  PAT  w- well do you think they're al:right I mean [er:           ]
6  DOC                                     [are they he-]
7      are they helping you. °when you take them°.
8  PAT  ↑WELL they er they they're helping me
9  DOC  yeah
10 PAT  but they're apt to make me feel a bit (0.2) ↓I suppose that's
11      what they're fo:r a bit docile like you know what I m(hh)ean

```

The doctor implicitly brings up the matter of a possible treatment change by the means of a question about what the patient wants to do about her medication in line 1. This manner of bringing up a treatment change is rare in this corpus and differs from the first two extracts, which are much more representative for the collected data. The exceptional nature primarily concerns the openness of the inquiry: there is a lack of a recommendation in relation to which the patient can position herself and the open-endedness of the question calls for an answer that is more elaborate than a *yes* or *no*. The doctor here gives more agency to the patient than the ones in the other extracts, and opens up for a proposition on her behalf. The preferred responsive action would be an answer to the question, but ↑*WELL*, in line 2 identifies a trouble source in the doctor's prior turn and signals an upcoming dispreferred action, which is indeed what follows in line 3 where the patient returns the question by asking what the doctor thinks. The trouble seems to lie in her capability to judge the efficiency of the medication based on her experience with it, and thus in the authority attributed to her, since her question asks for the doctor's opinion and orients to his professional authority.

Following the identification of the trouble source in line 2, the doctor continues his pursuit for an answer by performing a repair in line 4 in the form of a new more specific and closed-ended question orienting to the patient's experience: *do you find they work*. He thus guides the patient and specifies what needs to be known (whether the medication works) in order to reply to the first question (if they work, there is possibly no need for change; if they do not work, an alternative needs to be found). We then find the same pattern repeating itself, with the patient following up with an identification of the doctor's new question as a trouble source and a dispreferred action in the form of a returning question (*well do you think they're alright I mean*).

Again, in lines 6-7, the doctor repairs by asking a new question, which this time is a reformulation of the last question (*are they helping you when you take them*). The patient aligns by providing an answer to this last question and sharing her experience of the medication. The ↑*WELL* in this turn signals a trouble source on another level: the trouble no longer lies in her authority in answering the question, but in the fact that the question of whether or not the pills are helping her fails to seize the entirety of her experience with them. This is expressed by the *but*-construction following her response, which, similarly to the *yes but*-construction found in Extract 2, presents information that the doctor has failed to take into account: even though they are helping her, they do make her feel

docile like (line 11). In answering, the patient orients to her epistemics of experience and performs the preferred action following the doctor's last turn. However, this does not answer the initial question in line 1, and despite orienting to her own epistemic authority (although in a downgraded fashion, by epistemic hedges such as *I suppose* and *you know what I m(bb)ean*) as well as to her authority to answer questions, she manages to avoid the deontic authority to decide or propose what needs to be done with her treatment. Instead, she presents all possibly relevant information to the doctor so that *he* can decide based on this.

In contrast with the first two examples, the patient does not accept the doctor's inclusion of her in the decision-making process but avoids all agency and gives back the authority to the practitioner, perpetrating a power asymmetry between the two. There is thus a conflict between the doctor's orientation to patient agency and epistemics of experience, and the patient's orientation to the doctor's professional vision and authority. This conflict is not present in the first two extracts where the patients both align with the shared responsibility put in place by the doctor and accept enough agency to partake in the establishment of the treatment change.

Concluding remarks

We have thus seen two response scenarios to doctors reducing their authority and inviting the patients to participate in the decision about a possible treatment change. In the first scenario, the patients accept the agency attributed to them and participate as active members, either by accepting or resisting the treatment proposition. In the second scenario, the patient refuses the responsibility attributed to her by the doctor and disaligns with the given authority.

As we have seen, the way in which the doctors diminish their authority in the two cases varies. In the two examples of the first scenario, the doctors present a possible treatment in relation to which the patients are invited to position themselves. Just like in Peräkylä's (1998) findings concerning the diagnostic phase, the physicians let the patients in on their reasoning and make at least part of the medical knowledge accessible to them. The treatment option is furthermore introduced in a more or less hesitant and hedged manner, allowing the patients to have a say in the matter and endorse or question the proposition. In both cases, it is also formulated in a way that diminishes the commitment of a potential acceptance by presenting it as being subject to exterior factors that

may possibly change the final outcome (such as the availability of the treatment and the opinion of an occupational therapist). Despite the downgrading of the recommendations, their content is, however, clear to the patients, whereas, in the example of the second scenario, the proposition to change treatments is more implicit and the doctor presents the patient with the possibility to openly express her wish. Indeed, there is no actual formulation of a recommendation but the implied proposition to reconsider the current treatment is situated outside of the scope of the treatment recommendation and thus the five social actions associated with it (pronouncement, suggestion, proposal, offer, assertion) (Stivers et al., 2017; Stivers & Barnes, 2018). By asking the patient to give him her opinion without offering her any option to position herself against, the doctor thus gives her the authority to take an active and independent part in the consultation and to make a treatment proposition of her own.

The extent to which the doctors orient to the patients' agency in the two scenarios consequently differs: the patients in the first two examples receive a medically endorsed proposal to take into consideration while the third one has no explicit point of reference to depart from. Being asked to judge oneself what may be a plausible option thus entails a more important attribution of authority by the doctor and corresponds to a higher risk in the interaction. This may explain why patients being addressed a proposal align more with this attribution than the patient being asked an open question. If the goal is to increase patient agency in treatment decisions, it then seems plausible to assume that a proposition form such as a proposal (Stivers et al., 2017; Stivers & Barnes, 2018), showing what is possible from a professional point of view while giving the patient a chance to engage, is preferable over open questions where the patient has no medical expertise to fall back on.

It is also important to note that the outcome of the different treatment discussions may be influenced by factors such as the identity of the patient, the type and purpose of the consultation, and the condition for which medical care has been sought. One can expect a patient's experience of their condition to be of high importance in the agency they display: someone who has suffered from their condition for a long time is probably more knowledgeable about their disease and what treatments work than someone who goes to the doctor for their symptoms for the first time. The former may hence be more prone to rely on their epistemics of experience and express their preferences. However, this would suggest that there would be a resemblance in the agency of the patients in

Extracts 2 and 3, who both have a long history with their conditions and have tried different treatments, which is not the case. This might on the other hand be explained by the sensitivity of their respective conditions. The patient in Extract 3 consults for a mental issue, namely panic attacks, which is of a more taboo and stigmatised nature than physical conditions such as rheumatism. The fact that there is less general knowledge available on mental issues (especially at the time of the recordings, in the early 1990s) and that it may be harder to evaluate and distinguish one's symptoms in this domain may thus come into play. Something that may also affect the alignment with the authority attributed by the doctor is the reason for the visit, and it would be interesting to examine the significance of the fact that the main objective of the patients in Extracts 1, 2 and 3 is to get a diagnosis (where the patient presumably discovers a new set of practices related to her condition), register at a rehabilitation centre specifically to get new treatments (where there are certain expectations on behalf of the patient) and to get a new prescription (where a treatment change may not be not expected), respectively.

Notes

1. The author is grateful to the ASLAN project (ANR-10-LABX-0081) of the Université de Lyon, for its financial support within the French program "Investments for the Future" operated by the National Research Agency (ANR).
2. The following examples and definitions of each of the social actions are borrowed from Stivers and Barnes (2018, p. 1333). In *pronouncements*, the physician presents the recommendation as already determined (as in "I'll start you on X"). When it comes to *suggestions* and *proposals*, the physician is the instigator of the recommendation, but whereas with the *suggestion* the doctor "treats patient as decision maker and medication as optional" (as with "You could try X"), the decision-making is "treated as shared by doctor and patient" in the *proposal* and the recommendation is highlighted as speculative ("Let's try X and see how that goes"). In the *offer*, the "physician treats patient as having instigated recommendation and as the decision maker, thus treating medication as having been occasioned" (as in "Would you like me to give you X"), and, finally, with an *assertion*, "physician asserts a generalization about a treatment's benefit implying a recommendation but not proffering an overt directive" (as is the case in "X is good for this").

3. The transcriptions of the three extracts are inspired by the transcription conventions developed by Jefferson (2004) and Mondada (2018). Table 1 below shows an overview of the transcription key.

Table 1. Transcription key

[word]	Overlapping turns of talk	.	Final falling intonation
(.)	Pause of <0.2 seconds	,	Slight rising intonation
(0.3)	Pause longer than 0.2 seconds in seconds	?	Sharp rising intonation
.h, h	Inbreath, outbreath	↑, ↓	High pitch, low pitch
Wor-	Cut-off	°word°	Pronounced quietly
:	Prolonged vowel or consonant	#word#	Creaky voice
<u>word</u>	Stress	pat	Participant doing embodied action
&	Multi-line turn cut off by overlap (marked at the end of the line where the turn is cut off and at the beginning of the line where the turn resumes)	*word* *nod *	Delimitation of embodied action synchronised with corresponding stretches of talk or pause

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Please cite as:

Hagafors, M. (2023). Changing treatments: Patient responses to doctors downgrading their medical authority. In Nelson, M., Michanek, M., Rydell, M., Sayehli, S., Skogmyr Marian, K., & Sundberg, G. (Eds.). *Språk i praktiken – i en föränderlig värld*. Rapport från ASLA-symposiet. Stockholms universitet, 7–8, april 2022. [Language in practice – in a changing world. Papers from the ASLA symposium. Stockholm University, 7–8 April, 2022] (pp. 183–201). ASLA, The Swedish Association of Applied Linguistics. Stockholm. <https://doi.org/10.17045/sthlmuni.24321526>