Chapter 5

Conflicting agendas
Working towards common ground

Training vignette 7

In a RTP training room in Sydney a group of General Practice registrars are engaged in role-plays of challenging scenarios from clinical practice. In response to the medical educator's call for volunteers, one of these registrars takes the seat at the front of the room. His 'patient' enters and says: "Hello doc, I'm going to be very easy today doc all I need is some antibiotics".

As the interaction unfolds it emerges that the patient's symptoms are viral in nature. But the registrar's attempts to explain that antibiotics are unlikely to be helpful are resisted by the patient who persists with her request. She'd been refused antibiotics once before for the flu and had ended up in hospital with pneumonia. In her view that is based on her personal experience of illness, antibiotics are required to prevent this from happening again.

As the patient continues to insist on a prescription and the registrar struggles to present the medical perspective, the educator intervenes: "ok ok let's stop (.) what's happening here? ... There [are] totally different agendas here... Do you think you've established common ground yet? ... How can we establish common ground in this situation? What strategies (.) what phrases could you use?"

The notion of conflicting agendas that arise out of the disparate positions of doctor and patient is a long standing theme in General Practice. In an early and influential study, Kleinman, Eisenberg and Good (1978) introduced the concept of 'divergent explanatory models' to draw attention to the different perspectives that doctor and patient might bring to bear on an illness episode as they reason about its nature, cause and management. Whilst a patient's 'explanatory model' will be shaped by a wide range of factors, including knowledge and beliefs about their current illness, their previous illness experience, and observations of illness in others, a doctor's explanatory model is informed by professional experience and training (Usherwood, 1999, p. 8). Consequently, as illustrated by the role play scenario described above, doctor and patient may see clinical reality differently and this can lead to discrepancies in viewpoint about treatment and management. Further, as the medical educator's intervention in the role play suggests, such disparate positions need to be resolved for the interaction to move on. Common ground needs to be established so that the

consultation can proceed and mutually acceptable decisions about treatment and management can be made.

But how is this to be achieved? How can conflicting positions be accommodated? The following comment from a medical educator participating in the current study suggests that for expert practitioners, moments of conflict involving disparate beliefs and different ways of reasoning hold opportunities for enhancing mutual understanding between doctor and patient.

> Extract 4. Interview 5
>
> It's a sort of worldview isn't it (.) we assume that people reason as in a sort of Platonic type sense (.) a Socratic sense [but patients] don't necessarily use our logic (.) there's a dis-connect (.) and I think that you've got to accept that because of people's world-view and their beliefs (.) their fundamental beliefs about themselves (.) and about the cause of their illness (.) and the management of illness (.) that immediately presents us with a problem (.) so how can we work around that using the resources that they have (.) that they believe to solve the problem rather than our resources.....what you're trying to do is to get your world view and their world view to somehow co-exist together (Medical educator).

For this educator, the beliefs about illness, its cause and its management that patients display represent a potential resource that doctor and patient can work with and work on in ways that might move the consultation towards positive outcomes. This position aligns closely with that of Candlin (2002) who refers to the 'positive potential of alterity' or conflict in professional communication. From his perspective the successful handling of conflict involves not simply mitigating conflict so as to sustain interpersonal harmony and to protect rapport, but also managing disparate positions 'proactively'. In General Practice consultations, as educators' comments and training interventions suggest, this seems to involve making use of moments of dissonance to expand mutual knowledge so as to create a resource that can be drawn upon in pursuing common ground.

But how is such 'proactive management of alterity' (Candlin, 2002) actually accomplished in interaction? How is the patient's perspective made available to the doctor? How is the doctor's perspective made available to the patient? How do doctor and patient realise the complex task of melding disparate positions, meanings and ways

of reasoning so as to move towards mutual understanding about the nature of the patient's condition and what needs to be done?

Through close analysis of the discourse of a challenging PBA consultation involving conflicting positions over the need for lifestyle change, this chapter aims to offer a response to these questions. It aims to make visible and available to practitioners some of the interactional strategies that doctor and patient actually use as they struggle to achieve a measure of common ground.

Before turning to this analysis, I will draw upon the medical communication literature in order to consider how the theme of 'conflicting agendas' has been addressed from within the profession. I will also examine discourse analytical studies that relate to this issue so as to identify analytical themes that might be brought to bear on my analysis. I will then examine the theoretical models for managing conflicting positions that are influential in registrar training, and may be enhanced by discourse analytical findings.

5.1 'Conflicting agendas' in the medical communication literature

Two recent studies from within the medical profession (Vanderford, Stein, Sheeler, & Skochelak, 2001; Weingarten et al., 2010) are particularly pertinent to the theme of conflicting agendas. Each of these studies examines the issue in the context of primary care. Each draws attention to the prevalence of consultations involving disparate doctor-patient positions in this context and to the need for empirically grounded communication training that will assist doctors to manage this challenge effectively. However, as will be discussed below, these studies do not make use of transcribed interaction to examine what doctor and patient do in moments of conflict. Thus, from the discourse analytical perspective, they cannot enhance understanding of how conflicting agendas are actually managed by doctor and patient in co-constructed interaction.

Vanderford, Stein, Sheeler and Skochelak's comprehensive study (2001) was designed to identify communication topics to be addressed in an advanced communication curriculum for both medical students and practicing clinicians. To this end, they

collected first-hand accounts from eighty one experienced practitioners of "a significant encounter that illustrates a special communication challenge for you as a skilled clinician" (p. 263).

Using narrative analysis, these researchers examined the practitioners' accounts to uncover a large number of stories involving conflicting doctor-patient agendas based on disparate beliefs about the causes of the patient's condition and conflicting ideas about what procedures would be effective in resolving the problem at hand. Frequently, tensions between doctor and patient were associated with different positions on the relationship between lifestyle and health risk. Conflicts arose out of the doctor's belief that the patient's behaviour was contributing to their illness, and the patient's resistance to this idea, as well as to the doctor's efforts to persuade them that behavioural change would lead to better health outcomes. Such accounts resonate with the challenging PBA consultation to be analysed below.

Like many of the doctors interviewed for the current study, the experienced clinicians participating in the Vanderford study were also medical educators who were familiar with the communication training literature and the models and skills that this literature promotes for finding common ground (Stewart et al., [1995] 2003; Weston & Brown, 1987) and for motivating behavioural change (Prochaska & DiClemente, 1983). Yet, despite the capacity to draw upon this knowledge and expertise, most of the conflicts that the clinicians recount remained unresolved, and this prevented them from meeting clinical goals, such as determining a diagnosis or arriving at an agreed treatment plan. In the context of the challenging encounters that they describe, persuasive strategies that might normally have been successful were not effective. Standardised strategies such as eliciting and acknowledging patient's feelings, ideas, fears and expectations so as to align persuasive attempts with the patient's point of view, use of logic and cause-effect reasoning to link patient behaviours to their illness symptoms, and explanations of the benefits of following medical advice, did not accomplish the results that these doctors expected. Persistent persuasive attempts on the doctor's part often resulted in further insistence, anger, or withdrawal on the part of the patient. It appears that in such deviant consultations, involving circumstances that differ considerably from those that the doctors usually encounter, idealised text book models for motivating change and

standardised strategies for finding common ground do not readily apply "off the shelf" (Eraut, 1994, p. 43; Taylor & White, 2006) .

In light of this, the participants in Vanderford's study (2001) called for skills that would enable them to more effectively manage the types of conflicts that they describe. Specifically, and of particular relevance to the current project that examines the management of disparate agendas in the context of a lifestyle change consultation, they called for new approaches that would enable them to meet "the challenge of getting patients who are in the pre-contemplation stage of changing behaviours...to consider change" [21] (Vanderford et al., 2001, p. 275). In response to such requests, and drawing upon the doctors' narrative accounts, the researchers identified topics for an advanced communication curriculum that would include:

- training in motivational interviewing including recognition of the stages of readiness to change and the use of stage appropriate persuasive tactics;
- guidelines and practice in eliciting and understanding patient agendas, assumptions and health beliefs so that attempts at persuasion might make sense within the patient's life-world and
- guidelines for de-escalating anger and confronting denial (p. 276).

It was not however, within the scope of their study to identify interactional strategies that doctors and patients use to manage disparate agendas. Narrative analysis examines participants' recounts of events. Thus it sets the level of analysis above actual talk. These researchers engaged with doctors' formulations and accounts of what happened and what was said in challenging scenarios rather than with the actual interaction. Consequently, the question of how conflicting agendas are actually dealt with in situ remained to be answered. Empirically derived strategies that might inform their communication curriculum were yet to be identified and described.

[21] 'Pre-contemplation' refers to a phase in 'the stages of change model' (Prochaska and DiClemente, 1983) that is frequently invoked in motivational interviewing around lifestyle change. According to this model that will be described below, patients move through predictable stages in accomplishing behavioural change. To be successful in motivating change, doctors' interventions need to be responsive to the stage that the patient is at.

A more recent study from within the medical profession (Weingarten et al., 2010) set out to describe both the nature of doctor-patient conflicts in General Practice encounters and the strategies that doctors use to cope with conflicting positions. Noting that the issue of conflicting agendas had received little attention in the medical literature (p. 94), these researchers aimed to increase understanding of the dynamics of doctor-patient interactions that include conflicts, so as to inform the design of effective training interventions.

Weingarten and his colleagues analysed nearly 300 videotaped routine consultations from Israeli General Practice contexts using an adaptation of the Roter Interaction Analysis System (RIAS). Described in section 3.2.4.1 of this thesis, process analysis, of which RIAS is an influential example, is an analytic method that makes use of mutually exclusive, pre-determined communication categories to extract utterances from their interactional context so as to derive coded empirical data for quantitative analysis. In the Weingarten study, quantitative analysis of recorded consultations was combined with focus group discussions on the topic of conflicts in doctor-patient communication, involving 56 General Practitioners. These discussions yielded types of conflicts and types of doctor coping strategies that informed the development of an extended set of RIAS categories specifically related to conflict. These were then used by trained investigators to codify utterances observed in the video-recorded interaction with a view to characterising these conflicts and identifying the coping behaviours of doctors.

The Weingarten study offers additional evidence for the prevalence of consultations involving disparate doctor–patient positions in General Practice, and highlights the need for further research and training in this area. Disagreements between doctor and patient were identified in 40% of the encounters examined. These included disagreement over diagnosis and treatment, over bureaucratic matters such as sickness certification, over matters relating to the rationing of health care resources within the Israeli public health context, and over the need for lifestyle change or screening tests. Using coding as an analytic method, these researchers arrived at statistically significant conclusions about the types of strategies that doctors used to deal with such disagreements. For example, in coping with tensions related to the allocation of rationed health care resources, such as tests or procedures, doctors were found to use the strategy of 'passive acceptance' of resource rationing rules in 41% of cases. That is, they refrained from telling patients

about rights of appeal or options available to them outside the national health package. Specific training in how to deal with such conflicts in ways that attend to patient's rights for information and transparency were a key recommendation of their study.

Clearly, this study is of importance in identifying the coping strategies of doctors who are caught between the financial constraints of a system involving managed care and the rationing of resources, and the needs and wants of their patients. It is of particular value in the context of Israeli General Practice in identifying the need for training that will help doctors to address this issue more equitably.

However, from the discourse analytical perspective, such a study, in its use of process analysis as an analytic method, cannot bring us closer to understanding how conflicts and disagreements between doctor and patient are actually managed in situ.

As discussed in detail in Section 3.2.4.1 of this thesis, the process of coding renders the interactivity of the consultation invisible (Heritage & Maynard, 2006a; Stiles, 1989). As the utterances of doctors and patients are extracted from their interactional context and reduced into predetermined codes, the codes themselves become the data for analysis and the interaction is discarded. Yet it is the interaction that provides evidence of how doctor and patient influence each other and adjust their behaviours in response to each other as they respond to conflict and struggle for mutual understanding. In addition, when the recorded consultation is observed through the lens of pre-determined categories, the creative and unconventional strategies that doctors and patients deploy are likely to be overlooked.

Further, process analysis, with its focus on the discrete utterance as its unit of analysis, functions to fragment the consultation and so cannot accommodate the fact that communication, including the interactional management of conflict, is a dynamic and cumulative activity (Sarangi, 2009). In the challenging PBA consultation to be analysed below, there does not seem to be a unitary moment when conflict between doctor and patient is resolved and mutuality is achieved. Rather, the pursuit of common ground appears to be gradual and progressive and regularly interrupted by further dissent. As Candlin points out (2001, 2002, p. 25), "... mutual understanding is always a shifting and temporary matter" and mutual agreement is "an unstable state of becoming". To

capture this emergent process requires examination of the unfolding discourse across an entire encounter, carried out in light of insights derived from previous discourse analytical studies that have examined conflict in interaction.

5.2. 'Conflicting agendas' in the discourse analytical literature

The consultation as a site of contestation between conflicting values and perspectives has been a long-standing theme of discourse analytical research in clinical contexts. Mishler's seminal study (1984), that was described in Section 4.1 of this thesis, explained the clinical encounter as a discursive struggle between the 'voice of the life-world' representing the patient's real world experience of illness, and the 'voice of medicine' representing the scientific attitudes and technical concerns of bio-medicine. In Mishler's study, the doctor initiated request-response-assessment structure that characterises the 'unremarkable interview' was viewed as a mechanism through which doctors controlled the interaction so as to marginalise patient concerns. In this way patient perspectives that might interfere with the bio-medical agenda or conflict with medical authority were seen to be suppressed.

Waitzkin (1991) expanded on Mishler's observations to argue that the underlying structure of medical discourse operates against the expression of a patient's personal troubles. Waitzkin found that doctors seldom addressed troubles associated with the life-world context of the patient's illness, such as difficulties with work, financial insecurity, or family roles. By proposing bio-medical and technical solutions to the patient's problems and ignoring the social context wherein the illness arose, he argued that doctors reinforced compliance with social conditions and life-world circumstances that were implicated in the patient's suffering.

Working within a similar tradition, other researchers identified specific mechanisms that functioned to side-line the patient's agenda from the discourse of the consultation. These mechanisms included formulations and interruptions that redirected topics away from the patient's problem agenda in pursuit of a bio-medical diagnosis (Beckman & Frankel, 1984; Beckman et al., 1985), interruption by doctors of patients' turns (West, 1984), and a predominance of doctor initiated questions (Frankel, 1989; West, 1984).

However, as a number of scholars have indicated (Drew, 2001; Maynard, 1991a) the concern of these early and influential studies was to show that and how doctors controlled the agenda of the medical interview. To this end the focus of attention was the behaviours of doctors rather than the interaction. Yet, as Heritage and Maynard point out (2006a, p. 363), "...the contributions of patients no matter how minimal are unavoidably implicated in the co-construction of the medical encounter". Doctor and patient jointly construct the medical visit, and jointly contribute to interactional conflict and its resolution. It follows that an examination of how conflicting agendas are harmonised and how common ground is accomplished needs to attend to the contributions of both parties.

Recent studies have taken a more interactional approach to consider the behaviours of patients as well as doctors in contexts where lay and professional perspectives are in misalignment. These studies are of particular value to the current project in that they draw attention to what patients do to resist a competing medical agenda, to present their own theories about what might be wrong and to pursue their own ideas about what they might need. Thus, these studies focus attention on conflict between doctor and patient as a co-construction, and its management as an interactional accomplishment.

Stivers examined decision making sequences in paediatric consultations (Stivers, 2005, 2006), and adult acute care consultations (2006) where doctor's treatment recommendations, in the absence of signs of bacterial infection, were at odds with parent/patient wants for an antibiotic prescription. As discussed and illustrated in section 3.3.6.1 of this thesis, participants in these interactions were found to orient to doctors' recommendations as proposals that normatively require parent or patient acceptance for the consultation to move to closure. In light of this normative requirement, parent/patient resistance to a doctor's proposal, either through silence or use of minimal continuers, functioned as a resource that put pressure to bear on doctors to negotiate treatment decisions that might be contrary to medical opinion but more favourable from the parent's point of view.

Stivers' findings resonate with other studies of patient initiatives (Gill et al., 2001; Stivers & Heritage, 2001) in showing that patients generally orient to the delicacy of challenging doctor authority or intruding on medical expertise by advancing their

positions implicitly and indirectly. But in an earlier paper, and using the same data source (Stivers, 2002), she provides evidence of a small number of encounters involving more overt confrontation of the medical position. Parent actions in these encounters align more closely with the active, sustained resistance to the doctor's perspective displayed in the PBA consultation to be analysed below. These actions include: direct requests and statements of desire that assert the parent's preference for antibiotics in spite of the doctor's contrary position; persistent challenges to the clinically required preconditions for prescribing antibiotics through recourse to 'category entitlement' (Potter, 1996), that is to special parental knowledge about a child's illness experience that is not accessible to the doctor; and continued withholding of acceptance to non-antibiotic treatment proposals. The notion of 'category entitlement' is of particular relevance to the PBA consultation examined in this chapter. As an 'analytical theme' it sheds light on a key strategy that the patient uses as he invokes his own experience of feeling well, together with insider knowledge about his family medical history, to resist the doctor's position on the need for lifestyle change.

Within a climate of concern about over-prescription of antibiotics, it was Stivers' intention to identify the interactional strategies that parents use to exert pressure on doctors to prescribe inappropriately. In this way she aimed to inform the development of doctors' resources for responding to such pressures more effectively so as to maintain parent satisfaction, enhance parent understanding and knowledge and decrease inappropriate prescription rates (2002, p. 1127). Whilst her studies provide the researcher with valuable insight into how patients advance their positions in contexts involving conflicting doctor-patient agendas, it was not within the scope of her research to provide evidence for how such disparate positions might be proactively managed so as to achieve mutually acceptable outcomes.

An earlier and highly influential study by Maynard (1991a), offers valuable insight into what doctors do to manage alterity in ways that enable movement towards common ground. Through examination of encounters involving disparity between medical and lay perspectives in the context of bad news delivery to parents of children with developmental disabilities, he identified the 'perspective display series' (Maynard, 1989, 1991b, 1992) as a mechanism that allows for the melding of disparate positions so that the potential for conflict is reduced and mutuality is achieved.

Within the context of ordinary conversation, the 'perspective display series' (PDS) is an interactional strategy that is used when one participant has an opinion or assessment to give. Through this strategy "... one party solicits another party's opinion and then produces a report or assessment that takes the other's into account" (Maynard, 1991a, p. 458). In this way opinions can be delivered in ways that display sensitivity to the other's view and propose a mutuality of perspective.

Within clinical contexts, as Maynard has shown, the PDS enables the beliefs and perspectives of patients and parents to be brought into the discourse of the consultation. In situations involving disparity in viewpoints, this opens up the potential for the patient to eventually display a position or line of reasoning that is in accord with the clinical perspective, and for the doctor to co-implicate this position in the clinical reasoning process so that a measure of mutuality is achieved. Thus, 'alterity' (Candlin, 2002) can be managed proactively in ways that advance the consultation. As illustration, consider the following extract from Maynard's study[22]. In this extract, the mother initially takes a 'no problem' position in relation to her child's condition that is at odds with the clinical perspective that her child has a disability that will require special schooling.

1	Dr.E:	How's B doing?
2	Mrs M:	Well he's doing uh pretty good you know especially in the school.
3		I explained the teacher what you told me that he might be sent
4		into a special class maybe, that I wasn't sure. And HE says you
5		know I asks his opinion, an he says that he was doing pretty
6		good in the school, that he was responding you know in uhm
7		everything that he tells them. Now he thinks that he's not gonna
8		need to be sent to another
9	Dr E:	He doesn't think that he's gonna need to be sent
10	Mrs M:	Yeah that he was catching on a little bit uh more you know like
11		I said I – I- I KNOW that he needs a – you know I was 'splaining to
12		her that I'm you know that I know for sure that he needs some
13		special class or something
14	Dr E:	Wu' whata you think his PROblem is
15	Mrs M:	Speech
16	Dr E:	Yeah. Yeah his main problem is a – you know a LANguage problem
17	Mrs M:	Yeah language

(Maynard, 1991a, p. 469)

In response to the doctor's question (line 1) Mrs M. reports a conversation with her child's teacher that supports her position that her son is doing well and does not require

[22] Note that Maynard's data is represented line by line rather than turn by turn as in the current study.

specialised education. Rather than refute this position, the doctor restates the teacher's opinion (line 9) so as to encourage the mother to elaborate, and listens for her to broach some difficulty that is in line with his diagnosis and will allow for some agreement. At lines 12, 13 this becomes available as the mother offers her own assessment that some special class is required. The doctor does not offer a responsive second assessment but pursues elaboration with a 'perspective display invitation' (line 14) that obtains the mother's formulation of speech as her child's problem. At line 16 this formulation is incorporated into a diagnosis that confirms the mother's point of view. Thus, through deploying the PDS, the doctor has advanced the interaction gradually and through a series of staged steps, from a position of disparity to one in which mother and doctor are aligned. It appears that common ground has been collaboratively accomplished as a basis upon which mutual decisions about management can be made.

In another clinical context, that of genetic counselling, Lehtinen (2007) noted doctors' use of similar strategic action. In that study, where discrepancies between lay and professional perspectives arose, doctors were found to seek out information from their clients that was potentially useful in merging lay and professional knowledge so as to achieve agreement.

The 'perspective display series' provides a valuable analytical theme that will be brought to bear on the PBA consultation to be examined in this chapter. As analysis of the discourse of this encounter will show, it emerges as one important resource that the doctor deploys at critical moments as she works to advance the interaction by managing conflict in ways that incorporate the patient's understandings. Further, as the following observations from registrar training suggest, it may offer medical educators a useful concept for illuminating the process of finding common ground.

5.3 Teaching how to manage conflicting agendas – the training response

5.3.1. Working towards common ground

This chapter began with a vignette from registrar training in which doctor and 'patient' are engaged in a role-play scenario involving different agendas. As the registrar's attempts to dissuade the 'patient' of the need for antibiotics meet with continued resistance, the medical educator breaks into the role-play to encourage the doctor to 'find common ground': "Do you think you've established common ground yet?"... "How can we establish common ground in this situation?...What strategies...what phrases could you use? "

In General Practice training, as in the professional communication texts that inform this training (Silverman et al., [1998] 2005; Stewart et al., [1995] 2003), the exploration of the patient's point of view and the interchange of perspectives so as to reach mutual understanding is considered to be a guiding principle for managing disparate agendas. 'Finding common ground' is a frequently used metaphor for capturing this interactive and collaborative process.

As previously discussed (See Section 3.3.4), educators often invoke mnemonics such as FIFE and ICE to assist registrars to find common ground. These mnemonics are designed to prompt recall of standardised formulae and exemplar phrases that registrars might deploy so as to bring patients' feelings, ideas, fears, concerns and expectations into the discourse of the consultation. In this way doctors might incorporate the patient's reasoning into their own and align their efforts at persuasion with the patient's point of view.

But, like all models, such mnemonics are necessarily abstractions. Whilst devised by experienced practitioners, they represent idealised versions of what should be and are not informed by empirical analysis of what doctors and patients actually say and do in the give and take of situated interaction. Further, as discussed in detail in section 3.3.3, the exemplar phrases that illustrate these models generally represent only the doctor's contribution to idealised interaction in isolation from that of the patient, and are inevitably reductionist. In practice, the effectiveness of theoretical models, including

mnemonics, lies in the ability of the doctor to integrate such models responsively into the flow of interaction in a contextualised and 'veiled' way (Sarangi, 2007b). Their application needs to be worked out, moment to moment, at the local level of interaction.

Educators participating in the current study are cognisant that effective communication is locally managed and responsive to the unfolding context, and this awareness is reflected in their training methodology. Routinely, they provide registrars with opportunities to participate in role-plays so as to develop the ability to apply theoretical models in context sensitive ways. Through intervening at critical moments in these role-plays, educators encourage registrars to reflect on their practice and, in collaboration with their peers, to design their own solutions to communication problems on the spot. As illustration, consider the following transcribed extracts from the training session introduced in the vignette above.

Training vignette 8 [23]

23	Ed:	((Directs question to whole group)) How can we establish common ground in this situation
24		(4)
25	Ed:	What strategies (0.5) what phrases could you use
26		(3)
27	Prt:	((from the floor)) Something like well obviously you had some severe problem in the past that we need to check ((inaudible))
28	R:	((nods; directs utterance to educator)) ok I understand you've had a poor outcome with something similar last year :
29	Ed:	Well try it
30	R:	((resettles in seat to reorient towards 'patient')) So
31	Ed:	[Right ((resettles in seat))]
32	P:	[((resettles in seat))]
33	R:	((directs gaze to patient's face)) Look I understand you've had a poor outcome with falling sick last year you've been hospitalised (.) with pneumonia (.) having to have a lot of time off work umm but at the same time we've got to treat each case on its merits u:mm I think before we get to that stage I need to have a closer look and um see how we go (.) yeah (.) how how do you think about that
34	P:	Yeah ok go ahead have a look doc
35	R:	Ok
36	Ed:	Ok let's stop again (.) how do you think that went
37	R:	((inaudible))
38	Ed:	How does the patient react
39	P:	I feel like I'm going to get my antibiotics
40	Prts:	((Laughter))
41	Ed:	$$It's given you hope
42	Prts:	((Laughter))

[23] Abbreviations used in this transcript are as follow: Ed: medical educator; R: registrar participating in role-play; P: 'patient'; Prt: observing participants

43 Ed: ((directs question to whole group)) Do you think that was effectively establishing common ground

As the training session continues, the educator works with the registrar and his colleagues to refine their response to this patient. He encourages them to acknowledge the line of reasoning that has led the patient to conclude that antibiotics would have prevented the development of pneumonia in the past and would protect her in the present. But as seen in the following extract, he then goes on to provide exemplar questions that the registrar might use to prompt the patient to differentiate between her previous and current illness experiences. The patient's response may provide information that the registrar can work with so as to move the interaction towards common ground.

Training vignette 8 (continued)

49 Ed: 'Can you remember last time um can you recall when you you knew that things were deteriorating : (.) what changed' (.) so it addresses the question why (.) why is this time different or similar to last time (.) and try and get that sort of detail out of it (.) and she [the patient] might say 'well actually I was starting to get better and then I developed this cough that was quite different (.) and I developed a fever' (.) and so you've already sort of differentiated the two illnesses and given um today's illness a better context (.) in comparison to the previous illness (so that's the sort of thing to do)...

When viewed through a discourse analytical lens, this educator appears to be modelling strategic use of the 'perspective display series' (Maynard, 1991b, 1992). His exemplar questions are invitations designed to open up the possibility that the patient may display distinguishing details about her illness experiences that the doctor can incorporate into his reasoning about treatment. In this way doctor and patient positions on the use of antibiotics might be brought into alignment.

Could the value of this educator's interventions have been enhanced by explicit reference to the 'perspective display series'? At a workshop with medical educators that was part of the current study, educators considered the value of discourse analysis to training. In their view, discourse analysis can offer a vocabulary to better describe what they do and what they observe registrars doing:

Extract 7. Medical Educators' Workshop

"....it alerts us and highlights what we are actually doing and looking at.... (.) I think that it's really valuable"

"This [discourse analysis] is helping us to clarify and describe these tools and tricks that we're trying to teach" (Medical educators)

Further to this, discourse analysis may offer concepts that not only assist educators to describe what they do and see, but also have general applicability. In training workshops, educators frequently share specific examples of language use designed to respond to a particular moment in a particular interaction. Of themselves, these utterances may not be applicable across different contexts and situations. Analytical themes such as the 'perspective display series', that are derived empirically from the analysis of transcribed, naturally occurring interaction, may provide registrars with useful concepts that can absorb exemplar phrases and apply in a particular instance but also reach beyond specific cases to have wider application across a range of contexts.

5.3.2. Managing resistance to behavioural change – a theoretical model

A theoretical model that is particularly pertinent to the lifestyle change consultation that is the focus of this chapter, is 'the trans-theoretical model of behavioural change' (Prochaska & DiClemente, 1983), commonly identified as the 'stages of change model'. At RTP training workshops observed by the researcher, educators draw upon this model to provide registrars with a framework for motivational interviewing in clinical contexts that require lifestyle change.

The model is derived from a comprehensive study of the attitudes and behaviours of 872 people engaged in smoking cessation (Prochaska & DiClemente, 1983, p. 390), and has since evolved to become a widely used tool for motivating change in a range of contexts, including drug and alcohol addiction and the management of chronic conditions. The model is empirically grounded in the accounts of people who are in the process of change. It is not however informed by examination of what doctor and patients actually do and say as they interact in clinical contexts in which behavioural change is an issue.

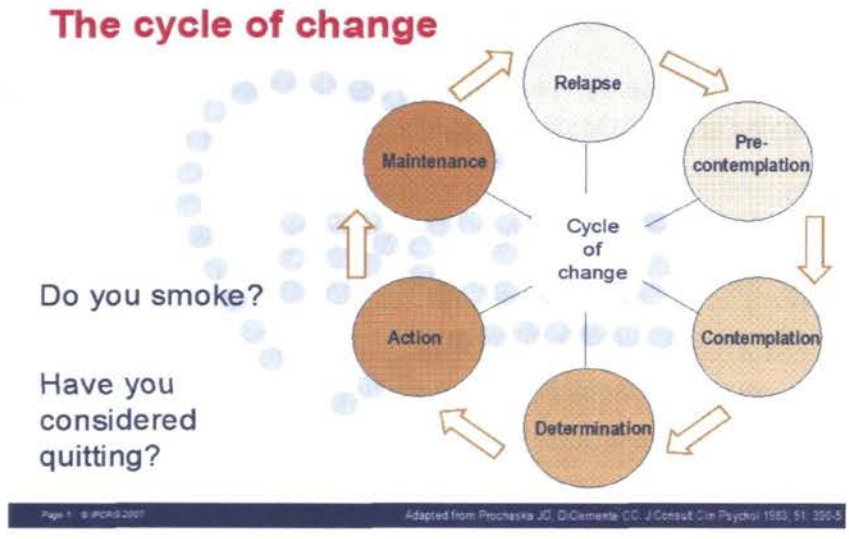

Figure 12: The cycle of change (Prochaska & DiClemente, 1983)

According to the model, patients engaged in behavioural change progress through predictable stages before reaching the point of readiness for action. Each stage represents a variation in the patient's perception of health risk and in their willingness and motivation to act, and at any point in the cycle they have the ability to relapse or regress. For a practitioner's intervention to be effective in motivating the patient towards permanent change, it needs to be responsive to the stage that the patient is at.
From a discourse analytical perspective, such interventions would also need to be 'recipient designed'(Candlin & Candlin, 2002a; Drew & Heritage, 1992). That is they would need to be carefully matched to the patient's perceived state of readiness to receive the doctor's information at a particular moment in the interaction.

The model includes suggestions for appropriate interventions to move the patient forward at each phase of the cycle, and in training workshops observed by the researcher these strategies were often accompanied by exemplar phrases, as illustrated below.

Stage	Possible Intervention	Exemplar response
Pre-contemplation The patient does not see their behaviour as a health risk, or not to the extent that others might see it. The patient is not intending to change their behaviour in the near future	Feed back about results of screening test and information about the link between these results and hazardous behaviours	P: My father lived till he was 85 and he smoked all his life D: He was very lucky. You may have his genes or you may not. The fact remains two out of five people die early because of smoking. Already you're finding that colds take a long time to clear and this tells us that smoking is already doing you harm.

The issue with such standardised interventions and devised responses is that they are not grounded in the analysis of contextualised interaction. Like the mnemonics and exemplar phrases for finding common ground that were discussed above, they represent an idealised version of what could be that may not transfer easily to practice. Indeed, in the context of the challenging consultations described in Vanderford's (2001) study described above, standardised interventions, such as the use of logic and cause effect reasoning to link hazardous behaviours with symptoms and test results, sometimes resulted in increased resistance, anger and withdrawal on the patient's part. It would appear that professional communicative expertise is realised through 'some-event and person-sensitive performance' (Candlin & Candlin, 2002a, p. 119) rather than through recourse to pre-conceived interventions and idealised phrases. Such expertise is displayed through discursive choices in specific, local interactional contexts. Close analysis of the discourse of lifestyle consultations may be able to make visible and available to medical educators what doctors and patients actually do and say at critical moments of patient resistance to medical advice. It might uncover some of the strategic resources that doctors deploy to manage this resistance in ways that move the consultation forward. These new understandings might offer a basis for a more interactional approach to training for accomplishing behavioural change.

It is important to note that within the world of clinical practice, the stages-of-change model is not uncontested. Recently, from inside the General Practice profession, the model has been critiqued for lack of clear evidence as to whether stage-based interventions are more effective than non-staged based strategies. In a review of studies evaluating the effectiveness of stage based interventions, Riesma, Pattendon and Bridle (2003) found that the research designs used were not optimal for establishing evidence

of effect. Nevertheless, individual studies have shown that stage based interventions can have useful effects. In the context of Spanish General Practice, Soria and colleagues (2006) found that motivational interviewing, involving the use of stage of change models, was five times more effective in achieving positive outcomes than offering brief advice. Within the context of Australian General Practice, stage of change assessment and intervention has become part of established clinical practice guidelines for supporting patients to achieve behavioural change (Zwar, Richmond, & Harris, 2008) and is a widely used training resource, as ethnographic observations carried out for this study affirm.

But how does this widely used model play out in practice? In particular, how might such a model be challenged in the context of complex co-constructed interaction of a challenging consultation involving disagreement and dissent? As Peräkylä and Vehviläinen (2003, p. 728) point out, "theories and models are general idealizations, whereas practices are carried out in situ".

In the complex and unpredictable contexts of real world General Practice consultations, normative models and recommended interventions may not readily apply, and associated exemplar phrases may not be pertinent.

I will now turn to analysis of the discourse of a PBA consultation where circumstances mitigate against the easy application of normative models for melding different perspectives and for motivating lifestyle change. In this consultation, doctor and patient display very different conceptualisations of the risk to health associated with the patient's behaviours and these conflicting perceptions are informed by different ways of reasoning. Given wide variation in the formulation of risk, contrasts in lay and professional reasoning about the nature of the patient's condition and how it should be managed, and the patient's overt and sustained resistance to the doctor's interventions, how do doctor and patient arrive at a stage where the patient is willing to contemplate change? Given disparate agendas, how is conflict managed in a way that sustains rapport and moves the consultation forward to accomplish a measure of common ground?

5.4 Consultation 3

5.4.1. The clinical context

The patient is a 73 year old man with a previously established diagnosis of the chronic condition Diabetes Type 2. This is a follow up consultation and the doctor and patient know each other well. The patient has come to see the doctor to receive results of recent tests, including a blood glucose level test.

5.4.2. Examiners' evaluations

Two RACGP examiners evaluated the doctor's video-recorded performance independently. Their global ratings on the parameter 'Communication and rapport', together with evaluative comments are as follows:

	Global rating	Comments
Examiner 1	Good	• Very challenging patient • Good attempt at motivational interviewing.
Examiner 2	Good	• Good eye contact • Good rapport • Very difficult non compliant patient

As examiners' comments suggest, the patient in this consultation is not a passive recipient of the doctor's reasoning and treatment recommendations. Rather, he appears to be a "a fully reflexive participant" (Drew, 2001, p. 267) in the interaction who deploys communicative practices that resist the doctor's estimation of his health risk, and embody his own meanings and mode of reasoning.

5.4.3. Brief prelude to analysis - a note on meaning and value

The measurement of glucose levels in the blood is a central tool for managing Type 2 Diabetes, and in a consultation such as this, shared understanding of what a high blood sugar result means is the foundation upon which doctor and patient can negotiate a

mutually acceptable management plan. This shared understanding is the basis upon which the consultation can effectively proceed.

However, meaning does not lie in wording alone but in the significance of that wording to the individual. What the term 'high sugar level' means to a patient and how it comes to be coupled with that meaning is shaped by many factors including the patient's illness experience and personal history.

In another clinical context, that of HIV/AIDS, Moore, Candlin and Plum (2001) draw attention to the manner in which concepts can be given different value by doctor and patient. In that context 'viral load' has many potential meanings and can be interpreted as a measurable bio-chemical property in the blood, as an indicator of wellness status, as a bearer of information about the effectiveness of treatment, or as an indicator of patient compliance with treatment regimes. In their study, these different meanings and values were found to index different discourses including the discourse of health measurement which construes health as objectively knowable and measurable, the discourse of health care which sees good health as a product of good health management, and the discourse of the patient's own personal health experience.

In a similar way, in the context of this General Practice consultation, doctor and patient bring different interpretations to the meaning of a high sugar level reading, shaped by different ways of reasoning and informed by their different personal and professional experiences. These disparate meanings and values, expressed through different discourses, contribute to the complexity of the interaction and affect the progress towards a mutually agreed to management plan.

On the other hand it is through the interplay of different meanings and the blending of different rationalities and discourses that the doctor and patient gradually and progressively achieve the measure of mutual understanding that is required for the patient to begin to contemplate behavioural change.

5.4.4. Analysis

5.4.4.1. Disparate interpretations of a 'bad sugar result'

As the consultation begins, disparity between doctor and patient perspectives, invoked through orientation to different discourses, quickly becomes apparent.

Extract 1. Consultation 3

1 D: Hello
2 P: Hello
3 D: ((sits))How are you
4 P: I'm well thank you
5 D: ((Laughter))
6 P: If I were any fitter I'd be dangerous ((chuckles))
7 D: ((directs gaze to computer screen)) Goo::d hh um except for I've got results here=
8 P: well
9 D: =that are ((directs gaze back to patient)) underwhelming
10 P: Underwhelming
11 D: Underwhelming
12 P: What do you [mean
13 D: [Does that surprise you :
14 P: What
15 D: Your sugar results are (.)
16 P: are lower
17 D: They're bad they're worse
18 P: $ Rubbish

From the opening turns there are signs that the patient brings his subjective experience of 'wellness' to bear on the value he gives to a 'bad sugar result'. It appears that to this patient health is something that is experienced and felt rather than observed or measured. At turns 4 and 6 he uses 'relational processes' of being (Halliday, 1985) to assertively ascribe the attributes of wellness and near dangerous levels of fitness to himself. Thus, from the outset, he sets out his subjective sense of being well as a challenge to what any bio medical evidence, expressed through the numerically formulated discourse of test results, might objectively indicate.

To the doctor on the other hand, health in a patient with Diabetes relates to a property in the blood that can be objectively measured, and a worsening blood sugar result means worsening health. From turn 7, she moves to counter the patient's subjective experience of wellness by referring to results that from her clinical perspective represent

scientifically observable fact "...except for I've got results here...that are ((directs gaze back to the patient)) underwhelming".

With marked stress on the initial syllable: 'underwhelming' (turn 10), the patient challenges the doctor's assessment. Then, at turn 16 he subverts the doctor's meaning by over-riding her turn completion to finally refute the medical interpretation of his test results with the resounding epithet 'rubbish' (turn 18).

Faced with such overt resistance to the value that she places on the results, and to the discourse of health measurement, the doctor needs to act strategically. Faced with contentious oppositional talk, she moves to head off the establishment of a self perpetuating 'conflict frame' (Norrick & Spitz, 2008, p. 1666) in which both parties are obliged to oppose each other and to defend their respective positions. Such a conflict sequence has already been set in train (turns 4-18), though tempered by an over-laying 'frame'(Goffman, [1974] 1986, [1983] 1997) of 'jocular banter'(Haugh, 2010). Through hyperbole and post utterance chuckles (turn 6) a smiling voice (turn 18) and the doctor's responsive laughter (turn 5) a playful atmosphere has been created. Yet, this jocular frame is simultaneously provocative and fundamentally confrontational. How does the doctor break this frame to head off conflict in pursuit of common ground?

5.4.4.2 Breaking the oppositional frame

Extract 2. Consultation 3

19	D:	((laughs)) (..) ((shift to serious tone)) They are (.) but does that surprise you :
20	P:	It does because I've gone on to that ah (.) gone off sugar and on to that thing (.) replacement what do they call it ahh ((gestures with hand as if searching for the word)) some special thing you buy it in the packets and ah
21	D:	Oh the splendour :
22	P:	Yes the splendour yeah yeah
23	D:	Ok
24	P:	Yeah I don't have sugar at all
25	D:	(0.5) Ok : (.) there's probably still room to improve your diet a little bit=
26	P:	=Probably : (0.2) but I eat good stuff : I don't go down to (.) MacDonalds or anything like that : (.) I I don't have ah I have pizza about once every six months : [or something like that=
27	D:	° [ok°
28	P:	= I have all home cooked [meals :] (..) ve::getables : ((rise end tone))
29	D:	[((nods))] Go::d ((slow nod accompanies and emphasises word))

30 P: meat : (.) ah fruit : I have a couple of pieces of fruit : (.) I don't drink enough water but I drink coffee so I don't know whether that's (.) where the problem is
31 D: °yeah °
32 P: I don't get enough exercise
33 D: That's that's one of the issues (.) exercise is one of them so the amount of food versus the amount that you exercise=
34 P: = what too much food
35 D: ((slight nod))
36 P: Probably probably
37 D: Well it's a balance isn't it
38 P: mm

At turn 19, the doctor's laughing receipt of the patient's dismissive 'rubbish' momentarily sustains the bantering frame to protect rapport and to diffuse tension. But then, a moment of silence heralds a contrasting shift in voice quality as the doctor moves to put the interaction onto an unambiguously serious footing. Plainly, directly and without mitigation she refers back to the test results to assert that they are indeed worse: 'They are'. With marked stress on the verb 'are' she ties her assessment to 'bad' and 'worse' thus emphasising her clinical perspective.

But her strategy does not lie in simply reasserting the clinical point of view. This is a delicate moment and her assertive, oppositional utterance, 'they are' (turn 19), could obtain an oppositional response and invoke a new unproductive conflict sequence. Nor does her strategy lie in presenting bio-medically reasoned arguments to support the clinical perspective. As suggested by the accounts of experienced practitioners participating in Vanderford's study (2001) (See Section 5.1 above), such an approach, at this particular moment and with this particular patient, might trigger further resistance rather than contemplation of health risk, and this doctor does not choose that path. Instead, she moves to break the deadlock of oppositional talk by inviting the patient to account for his perspective and to display his stance.

Her question: "but does that surprise you?" (turn 19) is a 'perspective display invitation'(Maynard, 1991a, 1992) that encourages the patient to expand on and to account for his position. In so doing it opens up the possibility that the patient may broach issues or display a line of reasoning that is in accord with the doctor's view. In this way the patient's perspective that is informed by his own way of reasoning could be co-implicated in the clinical reasoning process.

Note that at turn 20, in response to the doctor's invitation, the patient himself introduces the clinical topic of compliance into the discourse, albeit to defend his adherence to an appropriate dietary regime. Within a social culture in which lifestyle related health problems are sometimes regarded as self inflicted, risk talk around lifestyle may be perceived by a patient as a threat to integrity (Linell, Adelswård, Sachs, Bredmar, & Lindstedt, 2002). To address such a threat, defensive face work needs to be done, and over a number of turns (20, 24, 26, 28, 30) this patient works to defend his face as he supports his position that his diet is compliant. Across this sequence the doctor listens with quiet attention, encouraging the patient to keep talking with softly voiced continuers and agreement token (turns 23, 25, 27, 31). At turn 25 she intervenes momentarily to suggest room for improvement in the patient's diet: ".. Ok : (.) there's probably still room to improve your diet a little bit". But, mindful of face, this suggestion is couched tentatively and mitigated by her use of the modal 'probably' and the minimiser 'a little bit'. Her priority at this point is not to assert her clinical point of view, but to sustain rapport and to seek out material that she might use strategically to align the patient's lay perspective with her own.

At turn 32 this material is made available to her as the patient states in unqualified terms that he doesn't get enough exercise. Then, at turn 33, clinical reasoning and patient reasoning align as the doctor confirms this as a factor related to his bad test results: "that's that's one of the issues...". At the same time as she incorporates the patient's lay reasoned perspective into her own, the doctor moves strategically in an attempt to extend the knowledge that informs the patient's 'reasoning space' (Hamilton & Bartell, 2011). Deploying the strategy of 'converting'(Maynard, 1991b) she reformulates the patient's version of the problem to convert the single factor of exercise into one of two related issues impacting on his sugar levels: "....exercise is one of them so the amount of food versus the amount that you exercise". In this way food is reintroduced as a candidate problem as she relates food intake and exercise using the more technical discourse of ratio and balance. At turn 34 the patient indicates understanding of this line of bio-medical reasoning by reformulating the doctor's more technical language in lay terms: " what too much food". Then, at turns 36 and 38 he offers his qualified assent.

As a consequence of the doctor's strategic use of 'the perspective display series' (Maynard 1991, 1992), and 'converting' (Maynard, 1991b), together with 'face-work'

(Goffman, 1969) to sustain a productive interpersonal relationship, the stark disparity between doctor and patient positions that was evident at the outset of the consultation appears to have been reduced. At this point in the consultation, lay and professional reasoning tentatively merge and oppositional talk has been re keyed as discussion. The patient is beginning to contemplate a possible link between his diet and his health.

But this merging of perspectives is momentary and fragile. As the interaction continues to unfold the mutuality that doctor and patient have accomplished so far is undermined by further dissent.

5.4.4.3. Positions diverge

This patient is not a passive recipient of medical reasoning, nor is he a passive recipient of the doctor's strategic actions. Instead, he plays an active role in shaping the interaction to pursue a line of reasoning that runs counter to the clinical point of view. As seen in the following extract, his formulation of the risk to health associated with his lifestyle continues to be informed by individual experience rather that bio-medical reasoning. Using the discourse of personal experience, he draws upon personal knowledge to refute medical evidence and to undermine the meaning that the doctor invests in his test results.

Extract 3. Consultation 3.

51	D:	.....do you check your sugars at home :
52	P:	Nope
53	D:	(0.3) Is there any chance of convincing you to do that
54	P:	No
55	D:	hh ((wry smile)) $ how come
56	P:	((settles back in seat)) Because I don't think I need to (.) I think it's ah ((coughs)) over rated this ah (.) sugar diabetes ((clears throat))
57	D:	((gazes at patient)) (1.0) .h < so you don't thi:nk > (..) it's going to affect you
58	P:	I don't think so (.) no
59	D:	How come :
60	P:	Well I don't know I look at my family history : (.) my grandmother got ahm type two diabetes and it finally killed her at ninety six : and my father got type 2 diabetes : finally killed him at ninety seven : I don't know they got it about my age : and they didn't seem to make much difference :
61	D:	((laughs)) So I'm challenging the family history
62	P:	Well that's what I [feel
63	D:	[and an

64 P: [And my father had bowel cancer at seventy two and again at eighty two and he still lasted until he was ninety seven
65 D: Did he last because he did what the doctor suggested he do :
66 P: No I don't think so I don't think he changed his mind at all :
67 D: ((smiling; casts gaze down)) # ok
68 P: He still used to eat his Yorkshire pudding and all that stuff =
69 D: so
70 P =and ((coughs)) my father in law (.) he's ninety four this year and he still (.) lives at home by himself and looks after himself and he's supposed to have (.) type two diabetes and he still lives on (.) la:rd and things like that you know (.) I don't know I don't know maybe the exercise is the answer I think
71 D: (0.2) ((wry laugh)) ((directs gaze back to computer screen)) You are a challenge (.) ....

From turn 52 the patient reinstates an oppositional frame with direct, bald, unmitigated responses to the doctor's questions (turns 52, 54). Once again the doctor works to head off conflict and to sustain rapport with smiling voice and wry smiles (turn 55) and a question that invites the patient to lay out his position and account for his stance (turn 59). But this time the doctor's strategic 'perspective display invitation' is ineffective. No propitious information that would enable a reformulation and consequent re-alignment of doctor and patient perspectives emerges. Instead 'How come :' at turn 59, elicits an extended life-world narrative in which the patient recounts a family history of great longevity in spite of Type 2 Diabetes. Here the discourse of health experience, informed by unassailable facts from the patient's family history, presents a challenge to medical reasoning. Further, the patient's defensive oppositional stance is augmented by the cumulative effect of the rising tones that finalise each new piece of evidence.

At turn 65, in a further bid for information that might support the medical position, the doctor seeks a relationship between the father's longevity and compliance with medical advice: "Did he last because he did what the doctor suggested he do :" But this question obtains an immediate dis-preferred response (turn 66) that soundly negates her presupposition. In light of his own evidence, including the fact that his 94 year old diabetic father lived on lard, the patient retreats from his previous concession that diet might be implicated in his test results. Lay and professional reasoning again diverge and the patient reverts to the 'pre-contemplation stage' of the model of change (Prochaska and DiClemente,1983).

Clearly, in this consultation common ground is a shifting and temporary accomplishment that is momentarily achievable but regularly interrupted by dissent. It

has constantly to be worked on interactionally, and, as the encounter proceeds, a level of mutuality is regained through the doctor's strategic interactional work that includes:

- face-work and humour to re-establish equilibrium that has been threatened by dissent
- topic management that accomplishes a shift away from a conflict frame
- the use of metaphor to intensify and illuminate medical information at critical moments
- recourse to inclusive pronominal forms that encourage the patient's collaborative engagement in clinical reasoning, as well as
- continued use of the strategy of 'converting'(Maynard, 1991b) to extend the knowledge that informs the patient's 'reasoning space'(Hamilton & Bartell, 2011).

5.4.4.4. Regaining ground

Extract 4. Consultation 3

71 D: (0.2) ((wry laugh)) ((directs gaze back to computer screen)) You are a challenge (.) I guess in the past too yo:ur overall your overall sugar control hasn't been too bad (.)just with watching your diet
72 P: mm
73 D: But it's shot away now it's actually=
74 P: =Maybe its um I better start exercising
75 D: Yea: h we: ll I think it's probably more than that (.) let's just have a look see your HBA 1C is nine point one
76 P: And what's the normal
77 D: Well (.) the goal is to have it around seven=
78 P: yeah
79 D: =And previously you've been down around seven (.) so (.) something's changed (..)[that we need to look at]
80 P: [((brings right hand to chin))] Something changed in the last twelve (.) six months
81 D: Ye::s
82 P: ((sustains hand to chin in thinking gesture across turn)) What's changed in the last six months
83 D: Maybe less exercise [and]
84 P: [my brother] died and eh he died at about er the end of September (..) a:h I had a bit of trauma with the (.) dad's estate I've been havin fights with the public trustee ((chuckles))
85 D: Oh how come
((lines 86 to 92 deleted to protect patient confidentiality))
93 D: So you've had a few things on your mind

94 P: Right
95 D: And you may not have been paying as close attention to your eating
96 P: Well probably not I was probably gorging myself you know ((chuckles))
97 D: ((smiles wryly)) [So ((glances back at computer screen))

At turn 71 the doctor again responds to dissent with wry laughter so as to diffuse tension and protect rapport in this contentious interactional environment. But she then moves strategically to shift the talk away from the clinically unproductive topic of the patient's family history. The doctor's clichéd and arguably idiomatic utterance "You are a challenge" (turn 71) is, in Drew and Holt's terms (1988), 'interactionally terminal' and thus pivotal in accomplishing topic change and frame shift. As a kind of summarising assessment of the patient's stated position, and as an 'upshot' (Heritage & Watson, 1979) of what has gone before, it functions to close down the contentious topic of the patient's family history and to render it comparatively harmless (Antaki, 2007). This opens the way for the doctor to reintroduce the issue of the patient's own test results into the discourse.

As the doctor directs attention towards the patient's records on the computer screen (turn 71), she notes that in the past his glucose levels have been reasonably controlled "...just with watching your diet". This observation aligns with the patient's earlier assertion that his diet has been compliant (turns 20-30) and he receipts it with a minimal agreement token (turn 72). But how can the patient be persuaded to re-evaluate the meaning he gives to his current test results? How can he be moved to seriously consider the link between these results and his life-world behaviours?

The doctor's next move initiates a sequence that puts the interaction on to a footing of more collaborative and clinically productive talk. Through a variety of discursive devices that include the strategic use of metaphor, and the deployment of inclusive pronominal forms, the doctor works to regain a measure of common ground.

Strategic use of metaphor

Metaphor marks an attempt to make a segment of talk stand out. It is deployed by speakers at points where important interactional work is being carried out that relates to the central purpose of the discourse (Cameron & Stelma, 2004; Corts & Pollio, 1999). At this point in the consultation, the doctor deploys metaphor as a rhetorical strategy to

concretise and augment crucial but abstract information about the patient's current sugar reading.

Note how at turn 73 the doctor moves to contrast the patient's current and past results. However, through her wording she does much more than simply to convey bio-medical information. She might have chosen to convey her message through neutral unmarked 'core vocabulary' (Carter, 2004, p. 115) such as 'your sugar levels have increased'. Instead her use of metaphor gives an affective contour to what she is saying that is expressive of urgency and intensity. Her utterance 'But it's shot away now...' (turn 73) makes a semantic link between the patient's escalating sugar levels and the fields of gunfire and perhaps shooting stars. It conjures meanings of precipitous speed and velocity. His results are not just up, they have shot away to some previously unknown level, almost out of sight.

By means of this metaphor the doctor works to help the patient to see abstract technical information in a new way so that he might give a value to the test results that is in line with her own. The patient's immediate latched response (turn 74) suggests that this bio-medical message, couched in emotive lay terms has had some impact. Further, it seems to occasion a shift in alignment between patient and doctor. In ensuing turns the patient joins the doctor to collaboratively co-construct a shared understanding of what the new blood sugar reading means and the changes that may have precipitated it.

Mutual engagement in this clinical reasoning task that leads the patient to momentarily reconsider the relationship between his lifestyle and his test results, is facilitated by the doctor's strategic use of inclusive pronoun forms, as well as by the strategy of converting.

Inclusive pronouns as a strategic device

Note how at turn 75 the doctor deploys the collaborative imperative form 'let's' to involve the patient in the task of consulting his records: "...let's just have a look see your HBA 1C is nine point one". In response (turn 76), the patient seeks clinical information about what constitutes a normal HBA 1C level. Thus he works to expand his own 'reasoning space'(Hamilton & Bartell, 2011) to encompass knowledge that will enable him to interpret the test results from a clinical perspective.

At turn 79, as the doctor voices her clinical assessment that some recent change is implicated in the elevated sugar level, she deploys the inclusive pronoun 'we' to involve the patient in reasoning about the nature of this change.

79 D: =And previously you've been down around seven (.) so (.) something's changed (..)[that we need to look at]
80 P: [((brings right hand to chin))] Something changed in the last twelve (.) six months
81 D: Ye::s
82 P: ((sustains hand to chin in thinking gesture across turn)) What's changed in the last six months

This strategy obtains an affiliative response as the patient appropriates the doctor's words in a mirroring repetition that is accompanied by a gesture of thoughtful conjecture (turn 80). In this way he aligns with her assessment and joins her in the reasoning process.

Then, at turn 82 the patient reformulates the doctor's statement: "...something's changed that we need to look at" into a clinical question: "What's changed in the last six months". Roles are momentarily reversed as he speaks in the voice of medicine to pose this clinical question that he and the doctor go on to answer. Doctor and patient are in alignment as they collaboratively engage in the task of accounting for his increased glucose levels.

Converting

A few turns later, the doctor again deploys the strategy of 'converting' (Maynard, 1991b) in order to bring the patient's reasoning into line with her own. In an extended narrative across a number of turns (84-92) the patient has reasoned that recent life-world circumstances, including the death of his brother and difficulties over his father's estate, have affected his health. Stress, he implies is a candidate reason for his rising glucose levels. At turn 93 the doctor interrupts this narrative with an 'upshot'(Heritage & Watson, 1979) and summary formulation that acknowledges this reasoning: '[So you've had a few things on your mind', to which the patient responds with a relatively strong agreement token: 'right' (turn 94).

93 D: [So you've had a few things on your mind
94 P: Right

95 D: And you may not have been paying as close attention to your eating
96 P: Well probably not I was probably gorging myself you know ((chuckles))
97 D: ((smiles wryly)) [So ((glances back at computer screen))

At turn 95 the doctor elaborates on her summary formulation to convert the single factor of stress into stress as a trigger for dis-attending to diet. In this way she attempts to admit an additional factor into the patient's reasoning space. Tentatively, with low modality and mindful of face, she suggests that under these difficult life circumstances, the patient may not have been attending to his diet. Her strategy meets with some success. At turn 96, with up-scaled modality from 'may not' to 'probably not' the patient increases the likelihood of this proposition. Further, he transforms the doctor's neutral core vocabulary item 'eating' to the expressive 'gorging'. With this choice of wording the patient evaluates his diet, particularly as it relates to the amount of food that he eats, as seriously non-compliant and perhaps even gluttonous. At turn 97 the doctor receipts this news, which is perhaps not news to her, with a wry smile. Momentarily, at least, doctor and patient are in alignment over the matter of his diet.

5.4.4.5. A fragile collaboration

At this point in the consultation, doctor and patient seem to have arrived at common ground about the factors contributing to the patient's elevated sugar levels. In accordance with text book models for accomplishing common ground (Silverman et al., [1998] 2005; Stewart et al., [1995] 2003), such shared understanding, that has been collaboratively accomplished, should provide a foundation upon which mutually acceptable decisions about the management of the patient's condition can be pursued.

But in this challenging consultation common ground is highly fragile. It cannot be relied upon but must constantly be worked on interactionally. As Candlin (2002) suggests, in situations involving conflicting positions there is rarely 'one Eureka moment' when mutuality is accomplished or shared decisions are reached. Rather mutual understanding is "... an unstable state of becoming, perhaps momentarily achievable, but regularly and continuously interrupted by alterity" (Candlin, 2002, p. 25).

As the consultation continues, new moments of conflict arise in the discourse as the patient actively resists the doctor's treatment recommendations (See turns 115 – 126 of full transcript). At turn 115 the doctor's proposal that the patient see a dietician obtains an immediate dis-preferred yet unmitigated response. A few turns later, in light of the patient's bald refusal to seriously attend to his diet, the doctor invokes the discourse of health measurement to share disturbing bio-medical information in a further bid to highlight the crucial need for action. She explains that if the patient were on medication, his existing sugar levels would warrant use of insulin. Yet still the patient resists this bio-medical discourse and soundly rejects consideration of medication in bald, direct terms: "But I won't go on tablets (..) I'm taking enough tablets as it is I rattle when I get up in the morning" (turn 126).

How can such recurring dissent be managed? What can the doctor do to deepen the patient's understanding of his health risk? How can she move the patient to a point on the cycle of change where he is ready to take action to manage his condition?

5.4.4.6. Towards deeper alignment

A few turns later an opportunity arises for highly pertinent, clinical information to be personalised and individualised and incorporated into the patient's reasoning space. Through the doctor's strategic use of what could have functioned as just a passing remark, a deeper alignment of doctor and patient perspectives is achieved

Extract 5. Consultation 3

132	P:	.... I get a bit short of breath now and again I suppose : I don't know (.) I don't know whether I'm going to have a heart attack but If I do I do : (.) that's (.) that's what happens : (...) I don't want to end up like my father even though he finished up (.) ninety seven=
133	D:	((Sustained gaze on patient's face across preceding turn; Slow nod indicating increased engagement))
134	P:	=he was a vegetable [for the last] three years
135	D:	[O::h] well then I might be able to (sell) you this way (.) the issue about a sugar like that (.) is that (..) if your sugar level is high in the blood a lot of the time it's thought to be toxic to the lining of your blood vessels=
136	P:	mm ((sustains gaze on doctor's face across next turn))
137	D:	=so causing (.) mini strokes (.) bigger strokes heart disease kidney disease peripheral vascular disease [so (.)] amputation legs :

138 P: ((sustains gaze on doctor's face [mm] yeah
139 D: The mini strokes (.) the little strokes are what you want to avoid because that (.) contributes to that (.) vegetable =
140 P: ((shifts back slightly; sustains gaze on doctor's face)) umm
141 D: = sort of state (.) losing memory so there's definitely value in treating your sugars and getting them down (..)
142 P: mm
143 D: If you're really saying (.) no ((hands in stop gesture)) [I'm not going to take tablets the:n=
144 P: [not at this stage

As this sequence begins, the patient displays a fatalistic attitude to his own mortality (turn 132). He reasons that a heart attack would be preferable to living to a great age and ending up like his father. Note how at turn 133 the doctor's body alignment, slow nod and fixed gaze combine to communicate her increased engagement with the patient and his narrative at this particular point. It is a point where valuable insights about the patient's perspective and mode of lay reasoning might be forthcoming and, in response to the doctor's heightened attention, the patient discloses that his father was a vegetable for the last three years of his life (turn134). This news is receipted with an elongated 'O::h' (turn 135) that conveys the doctor's recognition of its valence.

This is 'a critical moment' (Candlin, 1987) in the interaction. For the first time in the consultation the patient has disclosed a fear about his future health. From turn 135 the doctor moves strategically to engage in highly relevant bio-medical reasoning that draws upon scientific evidence to make a strong causal link between uncontrolled high sugar levels and the vegetative state that is the source of the patient's fear. Her contribution to the interaction is 'recipient designed'(Candlin & Candlin, 2002a; Drew & Heritage, 1992) , expertly matching the patient's perceived state of readiness to take on this information at this particular moment. It illustrates 'explicit risk talk' (Linell et al., 2002) that re-contextualises bio medical information in a way that relates directly and dramatically to the individual patient and, in this case, to the patient's fears.

The patient receipts this new bio-medical information with softly produced and attentive acknowledgement tokens (turns 136, 138, 140) At turn 142, he again rejects medication, but this time his rejection is qualified. His statement that he won't take tablets at this stage carries the implication that he may take them in the future.

This skilful melding of lay concerns with medical reasoning through a discourse that incorporates both the clinical world and the world of the patient's experience has some impact and results in a shift in the patient's stance. It appears that at this point in the interaction the patient has begun to seriously contemplate the relationship between his lifestyle, his sugar levels and the risk to his future health. This move to the contemplation stage on the cycle towards change, has been accomplished through the doctor's strategic discursive choices, and in particular through responsive, expertly designed and expertly placed 'explicit risk talk'.

5.4.4.7. Towards action

Yet, reflection does not necessarily lead reflexively to action. In this challenging encounter, contemplation of health risk does not lead easily, in a linear fashion, to mutual management decisions or to the patient's determination to take responsible action to attend to his health. Mutuality is indeed 'a constant state of becoming' (Candlin, 2002), and, as the consultation moves towards its close, the common ground that doctor and patient have achieved continues to be threatened by dissent. Moments of dissonance continue to arise in the discourse and these moments need to be worked on and worked with to sustain a therapeutic relationship, now and into the future, and to move the patient to a position where he is determined to act on his health.

We rejoin the interaction as the doctor attempts once more to persuade the patient to consult a dietician.[24]

Extract 6. Consultation 3

155 D: .....Would you at least try my nice dietician [whos' very sensible]
156 P: [No no no] not at the moment (.) I'll see how I go in the next six months
157 D: ((Drops head)) (0.3) ((raises head to gaze directly at patient)) Would you give it three months
158 P: No ((fall rise tone)) Six months
159 D: Four months :
160 P: No

[24] The opening turns of this extract were analysed in Section 2.1 of this thesis to illustrate the 'interdiscursivity' (Candlin, 2006) and 'heteroglossia' (Bakhtin[1935]1981)that characterises expertise in professional communication. Here this analysis is revisited in its broader interactional context.

161 D: ((sighs; turns gaze back to computer screen))
162 P: ((chuckles)) ## this is like sale of the century
163 D: ((loud peel of laughter)) Worth a try ((gazes at computer records then returns gaze to patient's face)) because you're not ideally treated
164 P: Well I don't think it's that bad (.) well what's the other (.) how's me thyroid
165 D: Yeah that's still not quite right either
166 P: Is that why I'm getting the sweats
167 D: ((turns head to gaze directly at patient and sustains gaze across turn)) Oh you've got sugars that are running astronomically high all of the time
168 P: Is that what' s giving me the sweats
169 D: mm
170 P: So I better cut out the sugars all together
171 D: Well it's not just sugar it's carbohydrates [It's pasta (.) potatoes (.) bread]
172 P: [well I better cut back the amount of bread] that I use instead of having four slices of bread I'll have to have one
173 D: Yes thank you
174 P: hh

Note how at turn 155 the doctor orients to her proposal as 'a minimal form of action'(Stivers, 2005, p. 64) . Through her use of 'at least' she implies that seeing a dietician is significantly less than the action she recommends. Nevertheless, the patient responds with a direct, reiterated refusal to comply (turn 156), although he goes on to offer the concession that he may reconsider in 6 months time.

In response to the dilemma that this continuing resistance presents, the doctor acts, creatively and spontaneously, to push the boundaries of the Discourse of the medical interview. From turn 157 she crosses discourse boundaries to bring the jousting Discourse of bargaining into the interaction as she pursues a further concession from the patient. Through expropriating voices from the world of a television game show, doctor and patient enter into a light hearted frame of playful negotiation that sustains rapport in spite of the patient's continuing and potentially face threatening rebuttals.

But still no concession is forthcoming and, at turn 163, the doctor moves strategically to bring this playful sequence to a close. As her gaze takes in the patient's records and then returns to the patient's face, she foregrounds her 'professional identity'(Roberts & Sarangi, 1999a) by reinvoking the voice of a doctor to remind the patient that he is 'not ideally treated'. This action puts the interaction onto a serious footing and reinstates a serious frame

Within this frame, the patient at first continues to downplay the significance of his sugar reading: "Well I don't think it's that bad" (turn 164). At turn 166 he seeks ratification of his line of reasoning that a thyroid condition is the source of the sweats he is experiencing. But with her 'oh' prefaced response (Heritage, 1998) the doctor indicates that this presumption is inapposite (turn 167). Once again the doctor invokes metaphor to give intensity and impact to a crucial clinical message. The patient's sugar levels are not just high, but running 'astronomically high all of the time' and this, rather than his thyroid is the cause of his symptoms. The sustained and serious gaze with which this emotive corrective is delivered intensifies its import, and across turns 70 and 72 the patient responds with begrudging commitment to take action to attend to his diet.

5.5 Summary of analysis

In this challenging consultation, involving disparate doctor and patient agendas, the accomplishment of common ground has emerged as a gradual process that is continuously interrupted and diverted by moments of dissent. In order for the consultation to move forward towards mutual understanding of the meaning and value of the patient's glucose test results, and agreement about what needs to be done, doctor and patient have engaged in constant interactional work.

This work has involved both 'retroactive and proactive management of alterity' (Candlin, 2002). Moments of dissonance have been managed as they arise so as minimise conflict and to sustain a viable interpersonal relationship between doctor and patient. This has been accomplished largely through invoking frames of wry humour and jocular banter as a face protecting overlay to an underlying discourse of dissent.

But at the same time, the doctor has worked proactively to make positive use of dissonance in ways that expand mutual understanding and move the interaction in a more productive and clinically useful direction. Through strategic use of 'the perspective display series' (Maynard, 1991a, 1992), the doctor has sought knowledge that would increase her understanding of the patient's perspective so as to co-implicate this perspective in the clinical reasoning process. Through use of the strategies of 'converting' (Maynard, 1991b) and reformulation she has worked to broaden the

knowledge that informs the patient's reasoning so as to bring this reasoning into line with her own. Through 'explicit risk talk'(Linell et al., 2002) that strategically melds bio-medical information with the patient's life-world fears and concerns, she has accomplished a shift in the patient's fatalistic stance towards his own health. In these and other ways that include the strategic use of metaphor to intensify her clinical message at critical moments, and the timely and effective deployment of different voices and identities to put the interaction onto a more productive footing, a measure of common ground has been accomplished.

This has not been achieved through the replication of pre-conceived interventions and standardised phrases, such as those invoked by the mnemonics FIFE and ICE, or through the easy application of the 'cycle of change model' (Prochaska & DiClemente, 1983). Rather, as close analysis of the discourse has shown, the disparate positions of doctor and patient have been gradually reduced through strategic discursive choices that are responsive to the moment across the entire encounter.

Chapter 6

The multi-party consultation
Adolescent patient[25], parent and doctor

Extract 6. Interview 4

I recently had a 16 year old who came in with his dad and he [the adolescent] just sat there and was a bit of a pain. But I engaged him and I asked him to look after the form and I asked him to remind his parents that it had to be done and I talked to him and by the end of the consultation he actually looked me in the eye and he was engaged. Yet at the beginning he just sat there and was surly and I could have just talked to the father. But you've got to work at a relationship (Medical educator).

Extract 5. Interview 2

... [I had] a difficult consultation yesterday where I had a non-verbal teenager and a mother who was in tears. I mean that's challenging.... a teenager who just doesn't open their mouth. But I still want communication to go on here. How are you going to make that happen? (PBA examiner).

In these extracts from ethnographic interviews conducted for the current study, experienced General Practitioners allude to the communicative challenges that arise in multi-party consultations involving adolescent patients and their parents, and the interactive work that needs to be done in order to engage with the young person as an autonomous patient.

In principle, General Practitioners are encouraged to see young people alone. As Duncan and Sawyer point out (2010, p. 113), the "mature minor doctrine" is well enshrined in clinical thinking about adolescent development, reminding doctors about the need to assess young people's developing autonomy and growing capacity to make rational decisions about their own lives. In keeping with this doctrine, guidelines on adolescent medicine (Chown et al., 2008) strongly advocate private, two-party conversations between adolescent patients and their doctors for part of each consultation. A doctor's decision about if and when to seek such a private conversation is to be informed by considerations that include cultural appropriacy, the individual

[25] In the General Practice literature adolescence is defined as a dynamic period of development between childhood and adulthood, beginning with the changes associated with puberty, culminating in the acquisition of adult roles and responsibilities, and spanning the age group 12-24 years(Chown et al., 2008). The term 'adolescent' is used interchangeably with 'young person'.

patient's stage of development, the nature of the presenting problem, and the extent to which the condition indicates the need for parent involvement in its management. Nevertheless, seeing the young person by themselves is encouraged as good, routine practice that provides the patient with the opportunity to form an independent relationship with a health care professional and to develop the skills to take increasing responsibility for their own health care (Chown et al., 2008, p. 30).

In addition, in light of studies that consistently show that concerns about confidentiality prevent some adolescent patients from seeking health care (Ford, Bearman, & Moody, 1999; Ford, Millstein, & Halpern-Felsher, 1997; Jones, Purcell, & Singh, 2005), time alone without accompanying parties is advocated to enable open patient-doctor communication about issues that have a major impact on adolescent health, such as sexual behaviours, substance abuse, and mental health.

In keeping with these principles, General Practice registrars are given specialised training so that they might negotiate with third parties in order to spend some one on one time with adolescent patients. For example, during a workshop for registrars on adolescent medicine observed at a RTP organisation in Sydney, and described in Chapter 1, the medical educator modelled exemplar phrases that registrars might use to carry out the face threatening act of asking a parent or carer to leave the consultation room:

> "Mrs Brown I'd like to spend five minutes talking with Annie by herself, as she's growing up now and she needs to take responsibility for herself as she grows up. So if that's ok, could you leave us together for a few minutes? Then you can rejoin us" (Medical educator).

Registrars were then given the opportunity to put such phrases into practice in context sensitive ways through role-plays of clinical scenarios.

Yet, despite principled guidelines (Chown et al., 2008; Sanci, 2001) that advocate private one on one conversations between doctors and young people, and despite training in the application of these guidelines, research suggests that most General Practice consultations involving young people in early and middle adolescence are multi-party. It appears that only a minority of adolescent patients, and in particular

younger adolescent patients, spend time alone with their doctor. In an extensive American study, Edman, Adams, Park and Irwin (2010) examined 4302 health visits involving 12-17 year olds to find that only 34% spoke with the doctor alone. These findings are reflected in the small sample of PBA consultations made available for the current project. Of 10 consultations with patients between the ages of 12 and 17, only two involved private conversations between the General Practitioner and patient. In one of these cases, a 16-year-old girl attends the practice alone to request a prescription for the oral contraceptive pill. In the other, a 14-year-old boy, who has been institutionalised, presents alone with a throat infection, at the direction of his institution. In all other instances, a parent attends with the adolescent and remains throughout the consultation. The doctor does not invite the parent to leave.

It is not within the scope of this discourse analytical study to canvass the reasons for this discrepancy between institutionally sanctioned principles that advocate private conversations with young patients and the realities of practice. In the Australian context, that task falls to experts in adolescent health who conduct on-going research into issues that might contribute to this situation, such as parental opinion about the limits of doctor-patient confidentiality (Duncan, Vandeleur, Derks, & Sawyer, 2010).

Rather, given that multi-party consultations routinely occur in the context of adolescent health care, this chapter is motivated by questions surrounding how the General Practitioner, adolescent patient, and parent manage the additional interactional complexities that arise in triadic encounters.

In light of the accepted principle that young people should be encouraged to become independent patients, how is the goal of patient autonomy pursued in the context of multiparty talk? In what ways does the triadic participation framework encourage and even make necessary the patient's dependence on others? How do participants in the consultation make use of multi-party involvement as a resource as they work to maintain and advance their positions and to achieve their goals?

I propose to address these questions through close analysis of the discourse of a PBA consultation involving a General Practitioner and adolescent patient who is accompanied by his mother.

Before turning to this analysis however, I will refer briefly to seminal sociological literature (Simmel, 1902) to develop a conceptual framework for understanding the structure and functions of the triadic group. I will also draw upon key discourse analytical studies of interaction in multi-party clinical settings so as to identify discourse analytical themes that might be brought to bear on my analysis. However, it should be noted that, with the notable exception of Silverman (1983, 1987) (See below), these studies have focussed on multi-party talk in paediatric contexts (Aronsson & Rindstedt, 2011; Aronsson & Rundström, 1988; Stivers, 2001; Tannen & Wallat, 1987) and in aged care contexts (Coe & Prendergast, 1985; Coupland & Coupland, 2001) rather than in the context of adolescent health.

6.1. The triad

In a classic paper, the sociologist Georg Simmel (1902) analysed group size to draw attention to the functional changes that occur when a dyad is formed into a triad. In a dyadic relationship, each participant is faced by only one other. Each must actually perform something, for the dyad relies on reciprocity, and the withdrawal of one participant destroys the whole. Duties and responsibilities cannot be shifted to the group and this dependency of the whole upon each is clearly visible to both parties. As Simmel points out "...each knows he [sic] can depend only upon the other and upon nobody else" (p. 45). Thus the dyadic encounter entails a 'peculiar intimacy' and intense absorption one with the other.

But when an additional member is added to a dyadic group, as happens when a parent or carer accompanies a young person to a consultation, qualitative changes take place in the interaction that open the way for a variety of relational configurations and for social actions that would not otherwise have been possible. When a dyad becomes a triad, as practitioners' comments at the beginning of this chapter suggest, the individual group member is provided with an avenue for turning over responsibility for the interaction to the collective (Simmel, 1902, p. 43). For example, an adolescent patient might feel that they can legitimately disengage from the interaction, shifting the responsibility for presenting their problem and discussing treatment and management to others, as occurs

in PBA Consultation 4 to be examined below. In a multi-party consultation, the patient may more readily opt to forego autonomy and to take on a dependent role.

In addition, the triad allows for the formation of coalitions and alliances between two members of a group to the exclusion of a third. In so doing the triad provides a social framework that enables the group to constrain an individual participant in pursuit of the collective purposes of the other participants. Alignments between two participants may put pressure to bear on the third party to conform. For example, in studies of triadic interaction in the context of aged care consultations, Coe and Prendergast (1985) and Coupland and Coupland (2001) have shown how the accompanying person might pursue a coalition with the doctor in an attempt to persuade an elderly patient towards a particular course of action, such as a particular behavioural change or a recommended treatment. Such coalitions may shift dynamically as the interaction unfolds and participants take up different positions in relation to each other in pursuit of their objectives. They may be sustained across extended turns or they may also be fleeting in nature. For example, in the context of PBA Consultation 4, to be examined in this chapter, subtle, fleeting coalitions between the doctor and young person appear to function so as to momentarily marginalise the parent and to strengthen doctor-patient alignment and rapport.

But, as Simmel (1902) indicates, the triad does not necessarily function to facilitate a participant's disengagement, exclusion or marginalisation from the group. Rather, in the context of multi-party talk, each member can gain by their common relationship with the other as they pursue a common purpose. In the context of triadic aged care encounters, Coupland and Coupland found, on the one hand, particular instances of "communicative disenfranchisement" (2001, p. 123) as family members and doctors 'spoke for' and 'spoke past' elderly patients. But they also found much evidence of collaboration between participants. As their findings suggest, even where an accompanying relative speaks for the patient, this cannot necessarily be interpreted as usurping the patient's role. For example, in one instance in their data it is the elderly patient's reticence and low involvement in the interaction that creates the need for her son to speak on her behalf, a situation that resonates with the relationship that plays out between mother and adolescent daughter in PBA Consultation 6 of my data, referred to in Section 3.3.6.1, as well as between mother and adolescent son in the encounter to be

analysed below. Similarly, in the context of paediatric consultations, Stivers found that whilst parents were ultimately most likely to take on the role of problem presenter and to speak on their child's behalf, this was most frequently an outcome of interactional negotiation, rather than the exercise of dominance or control (Stivers, 2001, p. 252). In further instances from Coupland and Coupland's study (2001), accompanying relatives were found to speak 'with' rather than 'for' the co-present elderly patient, facilitating their accounts by co-narrating problems, symptoms and histories. In these instances, multi-party talk constitutes an informational resource for the doctor as participants collaboratively validate, elaborate upon, and edit the emerging illness narratives.

Thus, it would appear that a triadic participation structure is neither inherently advantageous nor disadvantageous for the patient, for the doctor, nor, indeed, for the clinical trajectory of a consultation. Rather, as Coupland and Coupland suggest (2001, p. 124), the impact of the third party on the interactional development of an encounter will be highly variable according to how relationships emerge through talk, and play out between the various participants, moment to moment, in relation to their changing positions, purposes and communication goals, as the interaction unfolds.

6.2. Previous discourse analytical studies of multi-party talk in clinical settings

6.2.1 Early studies

A review of the discourse analytical literature has identified only two studies that specifically examine multi-party talk in the context of adolescent medicine. Silverman analysed discourse practices involving parents, adolescent patients and doctors in the specialised contexts of a cleft palate clinic for young people (1983, 1987), and an outpatients' clinic for adolescents with diabetes (1987). In each of these highly specialised settings, the young patient was positioned as an autonomous agent responsible for monitoring their condition or making rational decisions about its management. Yet, the interactional accomplishment of such autonomy was limited by the actions of doctors and parents.

As illustration, we may take Silverman's analysis of triadic interaction in the cleft palate clinic. In that context, where decisions were to be made about whether to proceed to cosmetic surgery to improve the patient's appearance, the young person was cast as owner of their feelings about their looks, and hence as an independent decision maker who was to speak for themselves on the matter of an operation. But despite this stance, the adolescent patients in Silverman's data had difficulties in establishing a place for themselves in the talk. Opportunities to engage in genuine decision making discussions were constrained by the actions of the other parties. For example, doctors consistently refrained from directly asking for the patient's preference regarding an operation. Rather, they sought the young person's feelings about their appearance, inferring from the patient's response to this inquiry, their preferences about whether to undergo surgery. As Silverman points out (1987, p. 167), it may be difficult for a patient, and particularly an adolescent patient, to talk about their appearance. Too much attention to one's looks may be considered by the young person as excessive self involvement and hence as morally doubtful. In Silverman's data, doctors' enquiries frequently evoked a non-committal response from the patient that was treated by the doctor as an indication of lack of concern about their looks, and hence lack of interest in undergoing an operation. Further, doctors seldom pursued a more committed answer. Instead, through exercising interviewer's rights to control the consultation agenda, they frequently acted to close off the 'elicitation of preferences sequence' and to shift the interaction to a new topic.

The young person's engagement in decision-making talk was further constrained by the doctors' practice of using clinical discourse to formulate a medical evaluation of the patient's appearance or to comment on the technicalities of previous operations. In Silverman's study, only parents, and never adolescent patients, responded to this more technical discourse, consistently aligning with the medical perspective that it represented. What is more, through intervening at such moments to comment on and agree with the doctors' clinical observations, parents were able to stake a claim to be next speaker. In this way, the adolescent patient was excluded from subsequent talk.

In the discourse of the cleft palate clinic, adolescent patients were positioned as owners of their feelings about their appearance and cast as independent agents with rights to decide upon further surgery. But even in this specialised context, such autonomy was

not realised in interaction. Silverman's findings alert the researcher to actions of doctors and parents in multi-party talk that might undermine the accomplishment of adolescent patient autonomy and promote their interactional dependence on others.

It is to be noted that the stance taken by doctors in the specialist settings examined by Silverman represented a marked departure from the usual practices of the day. By way of contrast, Silverman includes in his study observations from encounters with adolescents in a general diabetes clinic within a suburban hospital. In that setting, adolescent patients were positioned as passive recipients of medical advice.

In another context, that of paediatric consultations, Aronsson and Rundström (1988) examined turn-taking patterns that functioned to limit patient involvement in interaction. In their study, doctors frequently deployed terms of address that selected parents to speak for and about their children. These researchers argued that the child's contribution to the encounter was regulated by the actions of parents as well as those of doctors. In 52% of instances in which doctors addressed the child, parents were found to intervene in order to take up the child's turn and to take control of the interaction.

Subsequent studies of multi-party talk in paediatric contexts (Aronsson & Rundström, 1989; Pantell & Lewis, 1993) have suggested that children's involvement in interaction is further limited by topic control exerted by the doctor. In each of these studies, researchers found that talk directed towards children was typically relational and restricted to the affective domain, whilst topics associated with diagnosis or management were addressed to parents. Such differences in the role and topic taken up by the doctor, depending upon who is being addressed are also in evidence in Tannen and Wallat's (1993) case study of a paediatric consultation involving a child with cerebral palsy and her mother. In that study the doctor's interaction with the patient is restricted to a relational frame, enacted through a playful, joking speech register.

But to what extent do the actions of doctors and parents, including the doctor's selection of the parent as next speaker, the restriction of topics directed towards the patient, and parents' strategic interruptions of patient allocated turns, operate to control patient engagement in triadic interactions involving adolescents in primary care? In particular,

how far are such features in evidence in consultations enacted within the current social and institutional climate of General Practice?

6.2.2. A changing institutional order

Since the influential studies referred to above, the 'institutional order' (Berger & Luckmann, 1967; Sarangi & Roberts, 1999b) that provides institutionally appropriate norms for the conduct of adolescent medicine has undergone considerable change. Over the past two decades, landmark legal cases in Britain and in Australia [26] have prompted a paradigm shift in how adolescents and children are legally perceived. A legal view of young people as the property of their parents has given way to a view that recognises their developing maturity and their capacity to make independent judgements and choices on matters that affect their own future, including matters concerning health care (Sanci, Sawyer, Kang, Haller, & Patton, 2005). Further, this orientation to the developing autonomy of adolescent patients applies not only to specialised contexts such as diabetes medicine or cosmetic surgery, but also to the wide range of clinical contexts that arise in primary care. As mentioned at the outset of this chapter, the 'mature minor' doctrine is now firmly in place within the institution of General Practice in the Australian and British health systems.

In addition, in the wider social sphere of many contemporary cultures, as Tates and Meeuwesen (2000) point out, parenting has become less repressive and authoritarian and interaction between parents and young people is increasingly characterised by greater openness and egalitarianism.

Such shifts in the social and institutional order are reflected in institutionally sanctioned guidelines (Chown et al., 2008; Sanci, 2001) that inform and constrain what counts for appropriate communication with adolescents in the General Practice context. In accordance with these guidelines, adolescent patients are to receive developmentally appropriate information about their condition and to be actively engaged in all aspects of the consultation, including treatment and management decisions. Further, with regard

[26] Gillick v West Norfolk and Wisbech Area Health authority, 1986; Secretary, Department of Health and Community Services v JWB and SMB (Marion's case) 1992

to the capacity and maturity of the individual patient, their rights to autonomy and confidentiality are to be respected. Whilst the concerns of parents are to be addressed and, where appropriate, parents are to be involved in clinical discussions, "the key to effective consultation with adolescent patients" is considered to be "the establishment of a supportive and trusting relationship" with the young person (Chown et al., 2008, p. 27).

How might such principles play out at the micro-level of multi-party interaction? As Cicourel reiterates (1992, 2003, 2007), and as Layder succinctly states (1993, p. 102) "micro phenomena have to be understood in relation to the influence of the institutions that provide their wider social context". Findings from earlier studies of triadic interaction that draw attention to doctor and parent dominance in both adolescent and paediatric settings, may align less closely with discourse enacted in the context of contemporary adolescent medicine, with its focus on young people's engagement in all aspects of their health care. Indeed, even in paediatric settings, children have been found to be increasingly active participants in interaction. For example, in their study of changes in turn-taking patterns in doctor-parent-child triads over a 20 year time span, Tates and Meeuwesen (2000, p. 159) noted that older children in particular were increasingly likely to initiate turns and to interrupt adult interactions to assert their point of view.

Clearly, professional discourse in General Practice settings needs to be interpreted with reference to the contemporary social and institutional order. More recent studies of triadic interaction, albeit in paediatric and aged care settings, offer insights and analytical themes that seem to apply more readily to an examination of current practice.

6.2.3. Recent studies

In a comprehensive study that was introduced earlier in this chapter, Stivers (2001) used Conversation Analysis to closely examine doctors' next speaker selection practices and their consequences within the problem presentation phase of 100 audio and video-recorded triadic consultations in acute paediatric settings.

Through her commentary, Stivers draws attention to the implications arising out of who actually speaks to present the patient's problem. Who speaks is important because it is the problem presenter who has the primary opportunity to set out their concerns and to expand upon these in narrative terms. Further, which party presents the problem has particular bearing on the issue of patient autonomy as it is during problem presentation that participants "define whether or not the child will be treated as an autonomous patient with rights to narrate his or her own illness experience" (Stivers, 2001, p. 254). In the context of adolescent consultations, where the young person's growing maturity renders the requirement for socialisation towards autonomy and independence more immediate, the issue of who speaks to describe the patient's problem is thus particularly pertinent.

In addition, in triadic interaction, who speaks in response to the doctor's problem solicitation has consequences for who continues to speak and who goes on to participate in the ensuing interaction. With reference to the classic account of Sacks and colleagues, Stivers explains that a bias exists in turn taking that favours the "just prior to current [speaker] to be [the] next [speaker]" (Sacks et al., 1974, p. 712). This means that if it is the parent who responds to the doctor's question, it is likely that the young person will be excluded from the on-going interaction, as occurs in the opening phase of Consultation 4 that is to be examined below. In triadic consultations, as Stivers succinctly states, "speaking to the parent may make it more difficult to subsequently engage the child in interaction"(2001, p. 253). How the doctor accomplishes or fails to accomplish the shift from parent to patient involvement in such instances will be a focus of my analysis.

But what are the factors that shape who actually responds to doctor's questions in triadic consultations? Stivers' study has been of particular value to my analysis in drawing attention to the complex, co-constructed interactional processes that are in play. Like Aronsson and Rundström (1988), Stivers found that parents frequently take up turns that have been directed to the patient. But by attending to the fine-grained detail of the interactional process that is prompted by the doctor's solicitation, and not simply to who ultimately speaks, she was able to show that the problem presentation most often emerges as a product of interactional negotiation among doctor, parent and child, rather than as an outcome of doctor or parental control.

As illustration, take the following problem presentation sequence from Stivers' study. The patient is a six-year-old girl.

1	Dr:	So what's up today: .
2	Dr:	What's = 'uh matter
3		(1.4)
4	Dr:	Are you sick,
5		(.)
6	Dr:	Or (are) you just (coming) here to
7		play with me
8		(1.4)
9	Girl:	[I::'m sick, = [h
10	Dr:	[.hh [#u# = Hu : h?
11		(.)
12	Dr:	You're sick, Well what's u:p,
13		(1.1)
14	Girl:	I don't know [:,
15	Mom:	[B [etween yesterday and to[da:y: she
16	Dr:	[How -=hh [-hh
17		(.)
18	Mom:	You know it's (just)/(this) – nasal crap an'
19		It's gotton = it was gree:n _it was [(h) really =
20	Dr:	[Okay .
21	Mom:	= uh beautiful color this morning.

(Stivers, 2001, p. 274)

From the outset, the doctor selects the patient as respondent. Whilst the doctor's questions at lines 1 and 2 might be ambiguous in terms of which party they address, Stivers' analysis identifies several characteristics of a child friendly register, including higher pitch and child-like reductions:"What's = 'uh matter" (line 2), that indicate that the doctor is addressing the girl. Then, at line 4, the doctor deploys second person address to clearly and directly select the patient as next speaker.

Across this sequence, the child responds with silence (lines 3, 5) or utterances preceded by significant delays (lines 8, 13) that are indicative of reticence or interactional trouble. Yet the mother consistently refrains from taking up the turn that she might legitimately claim at these points. Instead, she orients to the child as the participant who has been selected by the doctor to speak. It is only when the child explicitly states that she does not know what is wrong with her (line 14), thus claiming an inability to answer, that the mother intervenes to speak on her behalf (line 15). However, in self selecting to describe her daughter's problem, the mother is nor usurping the child's turn. Rather her action is the outcome of an extended process of negotiation in which the doctor pursues

the child's engagement and the mother aligns with the doctor in orienting to the child as the participant who has the right and responsibility to respond to the doctor's questions and to present her problem.

Comparable processes are at work in the adolescent-parent-doctor triad examined later in this chapter. In this PBA Consultation, the patient's engagement in, or disengagement from the interaction emerges out of the interplay of such factors as the doctor's next speaker selection practices, the patient's use of gaze and other semiotic means to redirect turns or to withdraw physically from the encounter, the significance of silence, forbearance on the doctor's part in pursuing a response, and parent's actions in seeking a response from the adolescent on the doctor's behalf. Within the current social and institutional order of adolescent medicine, engagement in interaction also appears to be a product of complex negotiations involving all parties.

Coupland and Coupland (2001) and Aronsson and Rindstedt (2011) contribute further to an understanding of the dynamic complexity of multi-party consultations by providing evidence for the many relational configurations that are made possible by the triadic structure. In their recent study of triadic interactions in a paediatric oncology clinic, Aronsson and Rindstedt (2011) draw upon Goffman's 'participation framework'(1981) in order to show how parents take up various positions in relation to the doctor and to the patient. On occasion, for example, parents are positioned as spokespersons for their child. At other times, parents signal their alignment with doctors by way of such features as turn completions and emphatic acknowledgement tokens, thus positioning themselves in the role of doctor's ally so as to reinforce or amplify medical recommendations and advice.

Coupland and Coupland's study (2001), also referred to in Section 6.1 above, examines extended sequences of interaction at various phases of triadic encounters in aged care settings. As participants in these encounters take up different alignments each to the other, different roles and relationships are constructed that shift and change as the interaction unfolds. These shifting, fluid relationships may be advantageous or disadvantageous for the patient and for the trajectory of the consultation.

At times, for example, the triadic structure allows for collaborative relationships to form in which patient and third party co-articulate the patient's illness narrative to provide detailed accounts that inform the diagnostic process. At other times a reticent patient might turn over the role of reporting on their condition to the accompanying relative to speak on their behalf. At yet other times, as Coupland and Coupland's data reveals, momentary coalitions might form between doctor and relative constructing the patient in a dependent role, or shifting alignments might position the patient as an outsider to the interaction.

Take, for example, the following fragment from a consultation involving an elderly patient and her accompanying daughter. The issue of weight loss has been under discussion, and the doctor has just reminded the patient of the need to balance diet with exercise. At this point, the daughter intervenes in the dyadic interaction between patient and doctor to take up the topic of exercise.

31	Daughter:	It's exercise (.) this is the problem see it's exercise (.) because she'll wipe a couple of dishes up (.) she will do that but after that she's up in the morning she sits in the armchair =
32	Doctor:	= yes
33	Daughter:	And unless she's going to her meetings =
34	Doctor:	= yes
35	Daughter:	Well she's there until she goes to bed in the night (.) you know I can't get her active
36	Doctor:	[yes
37	Daughter:	And she's (laughing slightly) very stubborn for me doctor (.) to try to get her going (smile voice) she really is

(Coupland & Coupland, 2001, p. 141)

Here the daughter's use of the third person referents 'she' and 'her' positions the patient as the subject of talk between daughter and doctor. The elderly patient is momentarily constructed as a 'bystander' (Goffman, 1981) to the interaction in which the daughter aligns with the doctor to report on her mother's behaviours and to evaluate these as non-compliant with medical advice. However, whilst the doctor acknowledges the daughter's evaluation, he does not deploy third person reference to talk about the patient, and so resists entering into a confederacy with her. Rather, as Coupland and Coupland go on to show, his subsequent turns are 'resolutely patient-addressed' (p.143). In this way, the doctor re-establishes the patient as an active participant in the encounter and reconstructs her in the role of autonomous patient able to represent herself.

Coupland and Coupland's study traces the shifting alignments and relationships that play out in triadic consultations in aged care and the strategies that participants use to accomplish these relationships. In particular, these researchers focus on how wide ranging levels and dimensions of patient dependency and autonomy are constituted through the unfolding interaction. In this regard, their analytical approach offers a particularly valuable model for the examination of multi-party talk in the context of adolescent health, where the patient's development towards autonomy and independence is an important consideration.

I will now turn to analysis of the discourse of PBA Consultation 4 that involves a patient in early adolescence and an accompanying parent, in order to trace the shifting relationships that play out between doctor, adolescent patient and parent and their effect on the trajectory of the consultation. The adolescent patient emerges as a reticent interactant. Nevertheless, as I will argue below, rapport between doctor and patient is established, trust is developed and a measure of patient autonomy and responsibility is accomplished.

6.3. Consultation 4

6.3.1. The clinical context

The patient is a twelve-year old boy who attends the consultation in the company of his mother. This is a follow-up visit, however the patient has not seen this particular doctor before. He had previously presented with abdominal pain but results of blood and urine tests have not indicated an underlying physical cause for his problem. Today he has returned with the same complaint. As the consultation unfolds, the possibility of psycho-social causes for his medically unexplained physical symptoms begins to emerge.

6.3.2. Examiners' evaluations

RACGP examiners were in agreement in rating the candidate as 'good' on the parameter 'communication and rapport'. However, minimal examiner comment offers

scant evidence of the basis for this global assessment. Further, examiners make no reference to multiparty talk as an issue of concern in managing the interaction.

	Global rating	Comments
Examiner 1	Good	• Good patient communication.
Examiner 2	Good	(No comment recorded)

6.3.3. Analysis

6.3.3.1. The problem presentation sequence – patient autonomy at risk

The video-recording of this consultation begins at the point where mother and patient have already entered the room and taken their seats. The patient is seated beside the desk at a right angle to the doctor's chair in keeping with his role as 'the legitimate party for medical service' (Tsai, 2007). The mother is seated at a slight distance and between doctor and patient. This triangular seating arrangement allows for easy eye contact between all three parties. It suggests a collaborative stance and the possibility of multi-party participation in talk, whilst positioning the patient as the primary focus of the doctor's attention.

Figure 13: A triangular seating arrangement – primary focus on the patient

Yet, in soliciting the patient's problem, the doctor singles out the mother as respondent thus initiating a problem presentation sequence in which the parent speaks for and about her son. At this initial phase of the consultation, his right to be treated as an autonomous patient, able to describe his own illness experience, appears to be in jeopardy.

Extract 1. Consultation 4

1	D:	((takes seat; directs gaze towards mother)) What can I do for Matthew today
2	M:	Um well for the last(.) three months : =
3	D:	Mm mm
4	M:	= he's been complaining of (.) pains in his belly :
5	D:	Right
6	M:	We've come in here be[fore
7	D:	[((directs gaze to computer screen))
8	M:	((leans forward so as to direct gaze to computer screen)) and doctor (.) Dean I think got blood tests and urine tests done :
9	D:	Mm mm
10	M:	And they all come back clear
11	D:	Yep
12	M:	But he's still complaining about em so I don't=
13	D:	=ok ((directs gaze momentarily towards Matthew and then back to computer screen))
14	M:	= yeah I don't know ((shakes head)) [what] it's from ((chuckles))
15	D:	[Um] ((smiles as looks at screen))
16	M:	It's been just $$ going on for months an months
17	D:	So we haven't seen you since last year ((redirects gaze from screen towards mother)) until you came in this time to complain of the pain =
18	M:	Yeah
19	D:	((returns gaze to screen; then towards mother and momentarily towards Matthew)) = going on for two months it's now going on for three months
20	M:	[Yep]
21	P:	[((barely perceptible nod))]
22	D:	((types data into computer))

With her opening move the doctor combines vocal and visual means to unambiguously select the mother as next speaker. Note that she does not speak to the patient but refers to him by name (turn 1). As Lerner points out (2003, p. 182), in multi-party talk, use of an 'other than recipient reference term', such as a co-participant's name, functions to exclude that party as an addressed participant. Thus, by referring to Matthew in the third person, the doctor tacitly chooses the mother as respondent. This, combined with the direction of her gaze, makes evident to both parties that it is the mother who is the intended recipient of her enquiry and the person who is to present the reason for the visit.

In response to the doctor's problem solicitation, the mother takes the floor. Across turns 2 to 12, encouraged by the doctor's continuers (3,9,) and acknowledgements (5,11), she articulates her son's continuing complaints of abdominal pain and refers the doctor to his unremarkable urine and blood test results (turn 8). As the unaddressed party, and the person being talked about, Matthew is afforded the opportunity to opt out of the talk and

to take up the position of onlooker. Across this sequence, he sits back and silently observes the interaction between his mother and the doctor.

For a brief moment in this opening sequence the mother moves beyond her role as spokesperson for her son to pursue a fleeting, collusive alignment with the doctor that functions to momentarily reposition the patient from ratified onlooker to outsider.

14	M:	= yeah I don't know ((shakes head)) [what] it's from ((chuckles))
15	D:	[Um] ((smiles as looks at screen))
16	M:	It's been just $$ going on for months and months
17	D:	So we haven't seen you since last year ((redirects gaze from screen towards mother)) until you came in this time to complain of the pain =
18	M:	Yeah

At turn 14 she speaks for herself to express bafflement about the source of her son's continuing pain. Ostensibly, her words are to be heard by patient as well as doctor. But post utterance chuckles (turn 14) and smiling voice (turn 16) laminate her utterances with an overlay of meaning that seems to be intended for the doctor alone. In Goffman's terms her words are 'allusive' (1981, p. 134), carrying additional meaning that is directed to only one party. Against the backdrop of test results that have failed to uncover a physical cause for the patient' pain, she seems to allude to the possibility of an emotional basis for his on-going complaints. The doctor's veiled, collusive smile (turn 15) suggests that she has picked up the implication of the mother's words and is in alignment with her. Momentarily, mother and doctor enter into a confederacy that excludes the patient and positions him as an outsider to the interaction.

On the one hand, this brief, collusive alignment between mother and doctor has been advantageous to the doctor and to the direction of the consultation. Parents are likely to be reliable witnesses to their children's illness experience, and the mother's allusive words have provided a clue to a possible source of the patient's symptoms that the doctor will later pursue. On the other hand, such collusion is disadvantageous to the development of trust between doctor and patient, and the establishment of a supportive and trusting relationship is considered to be the lynchpin of effective consultations with adolescents (Chown et al., 2008; Donovan & Suckling, 2004).

It is perhaps in light of this that the doctor acts swiftly to re-establish a frame of direct and open talk. Note how at turn 17 she initiates a summarising statement that seeks the mother's confirmation of her earlier account of the patient's recent history. In this way she realigns with the mother in her role as spokesperson for her son, and repositions Matthew as a non addressed but ratified party in the interaction.

At this early stage of the consultation, Matthew has been positioned as interactionally dependent on his mother. Through the doctor's actions of selecting his mother as respondent, he has been released from the responsibility to speak for himself. Further, given the bias in turn taking in triadic encounters that favours the just prior to current speaker as next speaker (Sacks et al., 1974), it might be predicted that the mother would continue to speak on his behalf.

Yet, Matthew is the patient. As owner of his own illness experience he is the party best equipped with the knowledge required to answer questions about his symptoms (Sacks, 1984; Stivers, 2001, p. 253). In addition, as previously discussed, adolescent health guidelines require that General Practitioners promote the autonomy of young patients and actively engage them in all aspects of the consultation. In light of this, what might the doctor do to involve Matthew in interaction? How might a shift towards patient autonomy and patient engagement be accomplished?

6.3.3.2. The symptom history phase - establishing the patient's entitlement to speak for himself

A few turns later the consultation enters the symptom history phase. Across turns 24-79 (See full transcript but also below) the doctor pursues responses to a series of questions designed to ascertain such factors as the character, duration, pattern of occurrence, and intensity of the patient's symptoms. From her opening question, as the following extract shows, the doctor moves to reconfigure the triadic relationship that has been constructed thus far so that Matthew is repositioned from on-looker to the interaction to active and ratified participant.

Extract 2. Consultation 4

24	D:	((stops typing; withdraws hands from keyboard and directs gaze to patient's face)) Has it changed at all Matthew
25	P:	((returns gaze)) nope
26	D:	Not at all : ((glances towards screen))
27	P:	((slight shake of head))
28	D:	((orients head and upper body towards patient; brings hands together to enumerate symptoms on fingers)) And if I'm right your bowels work ok :
29	P:	((gazes at doctor for 1.5 seconds))
30	M:	[your]
31	D:	[Your poos are ok]
32	P:	((nods)) yeah
33	D:	Are they ha:rd are they soft
34	P:	((slight shrug))
35	D:	Are they normal
36	M:	((directs gaze to patient))What are they normal :
37	P:	((nods))
38	M:	((sustains gaze on patient's face)) Mostly soft aren't they
39	P:	((nods))
40	M:	((directs gaze to doctor)) mostly soft yeah
41	D:	((sustains gaze on patient's face; hands gently clasped together on desk)) Is the pain anything to do with when you poo :
42	P:	((shakes head))
43	D:	No ok and (.) when you pee : (.) does that hurt at all : is that all normal :
44	P:	Normal

At turn 24 the doctor disengages from the computer and directs her gaze towards the patient to inquire about changes in his symptoms. In itself, the gaze direction that accompanies her question is adequate to establish that the patient is the 'addressed recipient' (Goffman, 1981, p. 226) of her attention and the proper person to respond. But the doctor goes beyond what is required by also appending Matthew's name to her utterance. As Lerner states, the 'post positioned form of address', that is, first pair-part + name, is a device that "...underlines the very act of speaking expressly to the already addressed recipient"(2003, p. 185). In addressing Matthew by name, the doctor underscores that he, rather than his mother, is the intended recipient of her query.

But in deploying this device at this particular moment, the doctor appears to be doing more than simply re-specifying who is to respond. Lerner draws attention to the fact that this marked and rarely used address form tends to be employed when considerations beyond addressing are in play (p. 184). By speaking expressly to Matthew at this point, the doctor makes evident to both parties a shift in her stance and a realignment of her relationship to each. As she moves into the symptom history phase, Matthew is

positioned in the role of autonomous patient who is expected to speak for himself. By default, his mother is re-positioned from spokesperson to 'bystander' (Goffman, 1981) to the interaction.

This reconfigured participation framework is sustained throughout the symptom history phase. Consistently, the doctor deploys gaze and second person address to select Matthew as respondent to her questions and to sustain the mother's position as 'bystander' (See turns 24, 28, 31, 41, 43, 45, 53, 57, 59, 63, 74, 76, 78, of full transcript). But despite the doctor's actions, the patient is reluctant to talk. Moments of interactional trouble recur in which he displays difficulty in answering the doctor's questions (See analysis below). At such moments it might be expected that the mother would take up her son's turn so as to speak on his behalf. There is 'a preference for progressivity in interaction' (Stivers & Robinson, 2006) and in a triadic sequential environment where the selected speaker displays difficulty in providing an answer, the non-selected recipient is likely to feel pressure to respond. Yet, as the following analysis will show, the mother sustains a position on the sidelines of the interaction, poised to facilitate her son's responses but largely resisting opportunities to speak for him.

6.3.3.3. Interactional trouble - facilitating patient involvement

Consider once again the interaction in extract 2. At turn 29 Matthew's prolonged 1.5 second pause signals his difficulty in understanding the doctor's use of the more technical term 'bowels' (turn 28). As the mother moves to broker the doctor's meaning (turn 30), the doctor acts quickly to revise her own expectation of how to interact with this patient who is balanced on the brink of adolescence and whose interactional competence is, at this point, unknown. At turn 31, she reformulates her question using the more colloquial and childlike lexical item 'poos'.

Despite this shift to an accessible register the patient does not respond. With a slight shrug (turn 34) he displays his difficulty in providing a definitive answer to the doctor's question about the consistency of his bowel movements.

Extract 2. Consultation 4

33 D: Are they ha:rd are they soft
34 P: ((slight shrug))
35 D: Are they normal
36 M: ((directs gaze to patient))What are they normal ;
37 P: ((nods))
38 M: ((sustains gaze on patient's face)) Mostly soft aren't they
39 P: ((nods))
40 M: ((directs gaze to doctor)) mostly soft yeah

This is a moment when the mother might step in to offer a response. Instead, she advances the activity at hand by aligning with the doctor to attempt elicitations of her own. At turn 36 she relays the doctor's question to the patient. She then seeks the patient's confirmation that his bowel movements are 'mostly soft' (turn 38), relaying his confirmation of this assessment back to the doctor (turn 40). In this way she takes up an active but subordinate position in the triad, facilitating, and also corroborating her son's responses, rather than speaking for him.

The mother sustains this position across the symptom history taking phase. At moments of interactional trouble, she takes her place beside the doctor, orienting towards her son as the party who has been selected to speak and has the right and responsibility to respond. It is only when the patient displays emotional distress under the pressure to provide an answer that the mother intervenes to speak on his behalf.

Take the following extract from the final moments of the symptom history phase. Through a series of efficient, check list like questions (See turns 53-59 of full transcript) the doctor has just ascertained that Matthew's symptoms occur mainly on school days. She now continues this line of questioning to find out about the duration of these episodes of pain (turn 63).

Extract 3. Consultation 4

63 D: Ok (.) when you do get the pain (.) how many days or how many hours or how many minutes does it last
64 ((4.0)) ((Doctor and mother sustain gaze on patient's face across pause))
65 P: I dunno
66 D: A few minutes(.) or is it hours and hours (.) would it last between sort of like a meal time to the next meal time
67 P: .hhhh ((bites lip))
68 D: It's $$ ok it doesn't [matter if you can't remember
69 M: [Sometimes he goes to bed (.) with pains in the belly and

		he'll wake up in the morning and there's still pain =
70	D:	((sustains gaze on patient's face)) = still there
71	M:	yeah
72	D:	((sustains gaze on patient's face)) ok but does it go from one day to the next :
73	P:	no
74	D:	Ok °right° and (.) when you do have the pain(.) it's just (.) does it stop you from doing stuff
75	P:	nope
76	D:	You can still do things
77	P:	((slight nod))
78	D:	°Ok° (.) normal stuff like running around it doesn't catch you (.) it doesn't make you bend over
79	P:	((shakes head almost imperceptibly))°no°

Note the extended four second pause (turn 64) that follows the doctor's question. A response from the patient is due but is not forthcoming. Such prolonged silence at a 'transition relevant place'(Sacks et al., 1974) creates pressure for an answer and the mother might legitimately intervene to take up the turn. Yet she passes up the opportunity to speak and aligns with the doctor in a sustained, joint, 'gazing pose'(Lerner, 2003) that is directed towards the patient and produces his eventual response.

Figure 14: A sustained joint gazing pose (turn 64)

With this response however, Matthew claims inability to answer. "I dunno" (turn 65) is a 'non-answer response'(Stivers & Robinson, 2006, p. 372) that fails to further the doctor's activity of finding out about how long the pain lasts. Thus it provides another sequential environment in which the mother, who is 'in the know' about her son's illness experience, might legitimately speak on his behalf. But still she sustains her third party position on the sidelines of the interaction.

At turn 66 the doctor continues to pursue the patient's response with a reformulation of her earlier question that provides the patient with a new series of optional answers from which he might choose. But these objective, task oriented questions are not designed with relational sensitivities in mind. Cumulatively, they exert considerable pressure on the patient so as to produce an emotional response rather than an answer. At turn 67 Matthew displays distress with an intake of breath and by biting his lip.

At this, the doctor gives up on her pursuit. Her empathic reassurance, realised with a smiling voice (turn 68) not only expresses understanding of the patient's feelings but also releases him from the obligation to provide an answer. Only then does the mother intervene to speak for her son. At turn 69 she self selects as respondent to report on occasions when the patient's pain lasts overnight.

Notably the doctor does not allow the mother's intervention to disrupt the pattern of doctor as questioner and patient as respondent that has been established during this phase. Even as she acknowledges and assimilates the information that the mother has just provided, by way of a latched echoing of her words (turn 70), her gaze remains firmly focussed on the patient's face. From turn 72, as she resumes her questioning to find out more about the duration and intensity of the patient's pain, her turns are resolutely patient directed (74, 76, 78). In this way Matthew's position as the party responsible for describing his symptoms is maintained.

However, in this interactionally complex and clinically challenging consultation no single participation framework is sustained for long. Rather, as the interaction unfolds, the parties take up different alignments in relation to each other in pursuit of their purposes and goals. For example, as it becomes increasingly apparent to the doctor that Matthew's symptoms are unlikely to have a physical cause, she orients to the mother as a source of information about the emotional and social context of his illness. Further, as witness to her son's illness experience and to his life-world, the mother seems to feel that she has a responsibility to speak for herself on behalf of her son so as to offer interpretations and accounts for the doctor to assimilate into her clinical thinking.
How is the doctor to draw upon these accounts whilst fostering an independent and trusting relationship with the patient? How might these different alignments be accommodated in the discourse?

6.3.3.4. Managing disparate positions

As the following extract begins, the doctor's 'ok' prefaced utterance (turn 80) functions pivotally to bring the symptom history sequence to a close and to open the way for engagement with the mother about the nature of her son's condition. This shift in frame is reinforced semiotically as she redirects her gaze from patient to parent to disclose the challenge that symptoms such as Matthew's pose for a clinician (turn 80).

Extract 4. Consultation 4

80	D:	Ok (0.5) ((directs gaze towards mother)) [It's quite hard to tell sometimes what the nature of the pain is :]
81	P:	[((sits back in seat and looks into middle distance))]
82	M:	Mm
83	D:	Um =
84	M:	= The he he worri [he e is a worry wort]
85	P:	[((directs gaze towards mother then towards doctor))]
86	D:	Mm mm
87	M:	Which makes me think (..) it could be just worry I don't know but [its just constantly there all the time like
88	P:	[brings hand to chin and fixes gaze on desk; then on doctor's face))
89	D:	((directs gaze to patient)) and that's why I'm asking about you know whether it's school days mostly and whether at the weekend and school holidays you tend to have it less
90	P:	((nods slightly with hand to chin; gaze cast down))
91	M:	(inaudible) ((looks towards patient's face))
92	P:	((sustains down cast gaze))
93	D:	Which is what it sounds like so there may be something (.) about (..) going to school :
94	P:	((barely perceptible shrug gazes up towards ceiling))
95	M:	He doesn't like his teacher
96	P:	((directs gaze to doctor's face; raises hand to chin))
97	D:	Right
98	M:	And his teacher doesn't like him (.) so I don't know whether [that's got anything]
99	D:	[$$ you don't have long to go] with this teacher
100	P:	((patient sustains gaze on doctor's face and [smiles slightly))
101	M:	[((mother directs gaze towards patient; leans back ; smiles; chuckles)) (..) .....

Note how this realignment of the doctor with the mother provides the patient with the opportunity to opt out of the interaction. At turn 81 he disengages from the triad, settles back in his chair and, by directing his gaze into the middle distance, retreats into a private interactional space.

From turn 84 the mother moves to put forward her own theory about the nature of the patient's pain. Using 3rd person reference she describes him as a worrier. Face sensitivities seem to surround the suggestion of somatisation that this categorisation implies, and she advances this evaluation tentatively, with hesitations and restarts. Further, her reformulation of the more literal 'worrier' as the idiomatic 'worry wort' invests her message with an informality that functions to lighten its impact and to redress its force. Encouraged by the doctor's acknowledgement (turn 86), the mother goes on to hypothesise that the cause of her son's constant pain could be 'just worry' (turn 87).

This sequence constitutes a critical moment in the interaction. Matthew is present as 'over-hearer' (Goffman, 1981) to an evaluation of his personality and an account for his pain that might appear to cast doubt on the legitimacy of his complaints. Indeed, in response to his mother's assessment, he reorients to the interaction. From turn 85 he re-joins the triad, albeit as listener and on-looker, directing his gaze from mother to doctor in order to gauge the doctor's response (85, 88).

Trust seems to be at stake and the doctor avoids entering into coalition with the mother to talk about Matthew. Rather, at turn 89 she moves strategically to bring him into the interaction. Gaze direction combines with 2nd person address to select him as recipient of an utterance in which she accounts for the earlier questions about school that had contributed to his distress. Skilfully, in the very act of engaging Matthew and explaining the reasoning behind her face threatening questions, she maintains her affiliation with his mother. In linguistic terms her "and that is why.." prefaced utterance (turn 89) stands in a 'consequential logical relation' (Eggins, 1994, p. 105; Halliday, 1985) to the mother's previous turn. By picking up on and extending the mother's own utterance the doctor displays her alignment with her thinking. On the matter of a possible relationship between the patient's symptoms and worry, she and the mother are at one.

But how is she to sustain a viable therapeutic relationship with the patient as she pursues this face sensitive line of enquiry? To Matthew, the doctor is likely to represent a figure of authority, and questions that attempt to elicit disclosure of troubles at school meet with his resistance. At turn 90, he receipts and acknowledges the doctor's account with a slight nod, but he averts his gaze and offers no verbal response. The mother's

contribution (turn 91) is inaudible, but it is patient directed and likely to be her own attempt to elicit a response from her son. This too is unsuccessful and he sustains his down cast gaze (turn 92).

The doctor's next move (93) is carefully 'recipient designed'(Boyd & Heritage, 2006; Drew & Heritage, 1992; Sacks et al., 1974) to display her awareness of the sensitivities involved in pursuing this matter. Though intended as a question, her utterance is structured as a modalised statement that tentatively invites the patient to consider the possibility that his symptoms are associated with school: "Which is what it sounds like so there may be something (.) about (..) going to school :".

The 'modal adjunct' "may" (Eggins, 1994; Halliday, 1985) renders the doctor's presupposition as only a possibility, and hesitations and a rising intonation contour invest the proposition with additional uncertainty. But this non-coercive question, constructed with face sensitivities in mind, does not obtain an answer. Matthew's barely perceptible shrug (turn 94) constitutes a non-committal response, and his upward gaze towards the ceiling appears to be an attempt to avert further inquiry.

Figure 15: Averting further inquiry (turn 94)

Faced by her son's continuing reticence, the mother intervenes. Clearly, she feels that she has a responsibility to act and at turn 95 she initiates a response. Directly and simply, and without mitigation she states that he doesn't like his teacher (turn 95) and that his teacher doesn't like him (98). Once again, as his mother speaks about him, Matthew looks towards the doctor so as to assess her reaction to this potentially face threatening disclosure (turn 96).

At turn 97 the doctor receipts the mother's news with a relatively strong 'news receipt': "right" (Heritage, 1984a; Maynard & Frankel, 2006) that displays her recognition of its significance. Her next move however is patient directed. Strategically it attends to the patient's face sensitivities but it also initiates an affiliative sequence in which all three parties align as they take up a shared position in relation to the teacher.

99	D:	[$$ you don't have long to go] with this teacher
100	P:	((patient sustains gaze on doctor's face and [smiles slightly))
101	M:	[((mother directs gaze towards patient; leans back ; smiles; chuckles)) (..) .....

At turn 99, with a smiling voice that invests her utterance with a light hearted and sympathetic stance, the doctor aligns with the patient to reassure him that he won't have this particular teacher for much longer. The patient acknowledges this reassuring assessment of his situation with sustained gaze and a slight smile (turn 100). Almost simultaneously the mother joins this alliance with smiles and chuckles that display her own appreciation of the doctor's stance (turn 101). This affiliative sequence heightens perceptions of interpersonal warmth between doctor, patient and mother so as to build rapport. But it also puts the interaction onto a new footing. The previously face threatening topic of the teacher and problems at school has now been recast as a less onerous matter that can be more comfortably and openly explored.

6.3.3.5. Building rapport - Constant monitoring and reflexive empathic action

The triadic structure continues to invest this consultation with interactional complexity. As the encounter continues, and as the parties take up different positions in order to pursue their purposes and goals, alignments constantly shift and participation frameworks are reconfigured. At times the doctor enters into dyadic interaction with the mother that seems to exclude the patient. For example, following the physical examination phase she engages with the mother in order to share her clinical thinking. An ultra sound is suggested so as to rule out unlikely but possible physical causes for Matthew's pain, such as an inflamed appendix (See turns 132-145 of full transcript). At other times the mother dominates the discourse for considerable stretches of time, as

occurs for example when she intervenes to offer the doctor detailed constructions of life-world interactions involving the difficult teacher and her son (See turns 187-203 below). At such moments, Matthew, as the talked about party, is sidelined from the interaction.

But close analysis of the discourse of these sequences suggests that this doctor is constantly aware of the patient's presence, and constantly monitoring what he is doing and how he seems to be taking the talk. Arguably, this constant reflexive monitoring is one important way in which she builds rapport and accomplishes trust with this reticent patient. To use Goodwin's phrase she is responsive to 'the cognitive life of the hearer'(2007, p. 25) and its implications for her relationship with the patient and for the trajectory of the interaction. She acts accordingly.

Take the following example. As outlined above, the doctor has just been talking with the mother about unlikely but possible physical causes for Matthew's symptoms. We join the interaction as the doctor brings this sequence to a close.

Extract 5. Consultation 4

145	D:	Um so po::ssibly these might be causes but if he's got the pain and he can jump up and down ((gestures towards the examination bed)) quite so well it's probably not a severe pain
146	P:	((glances towards doctor then looks down))
147	D:	((Directs gaze to patient)) Now we don't doubt that you have pain (.) ok :
148	P:	((nods))
149	D:	that's the easy bit (.) we know that you've got pain =
150	P:	((nods slightly)
151	D:	= because you're telling us you've got pain (.)
152	P:	((gazes towards ceiling))
153	D:	what we sometimes find is that there isn't anything actually wrong to cause that pain (..) all right
154	M:	((nods; [directs gaze to Matthew))
155	P:	[((Directs gaze to doctor; nods more emphatically))
156	D:	All right : .....

Note the doctor's use of a stretched and emphasised modal adjunct, "po::ssibly" that invests the likelihood of physical causes for Matthew's pain with a high degree of uncertainty (turn 145). Note also how, in the same turn, she adds weight to this assessment by referring to his facility in getting up and down from the examination bed.

Up until this point in the sequence, Matthew had appeared to be disengaged from the interaction, sitting quietly with his eyes slightly cast down as mother and doctor talked about him. But at turn 146 he orients towards the doctor as she evaluates his pain. He then averts his gaze in 'a characteristic sign of embarrassment'(Heath, 1988). The doctor's next move is an empathic response that displays her awareness of this momentary bodily display and her understanding of its likely implications. It appears that Matthew may feel that his account of his pain is in question. As a consequence trust is in jeopardy.

At turn 147 she moves decisively to engage with the patient so as to reassure him that his experience of pain is not in doubt. This reassurance is marked in a number of ways. Through prefacing her utterance with the discourse marker 'now' the doctor announces the importance of the message to follow and directs the patient's attention to it: "Now we don't doubt that you have pain (.) ok :". By deploying the inclusive pronoun forms "we" and "us" (turns 147, 149, 151) she speaks not only for herself but for her professional colleagues, and arguably for the mother as well, as a body of people who know that he has pain and do not doubt the truth of his accounts. Then at turn 153, again using the inclusive institutional 'we', she refers to the experience of doctors in general including herself who sometimes find that physical symptoms cannot be medically explained. Matthew's pain seems to fit within this medically recognisable category and is thus legitimised both as a symptom and as a reason for visiting the doctor. At turn 155, he acknowledges this validation as he looks directly at the doctor and nods. His trust in the doctor's understanding of him seems to be restored.

Matthew continues to be a reticent participant in the consultation and the triadic structure continues to provide him with an avenue for retreat. Nevertheless, through constant empathic monitoring of his bodily responses to the talk going on, and her actions in response, the doctor is able to enhance rapport and to engender his trust. Consider one further illustration from a little later in the encounter. As this extract begins the doctor is engaging with Matthew to find out more about his troubles with the teacher.

Extract 6. Consultation 4

185 D: Is the teacher picking on you or is it just
186 P: Ohh it's um two other people too
187 M: She seems to single out the three of them
188 D: mm
189 M: cause they're not real brilliant I think she ( ) like she (.)
190 P: ((directs gaze down towards corner of the desk))
191 M: he's come home nearly every day and says that she's yelling at him cause(.) he can't do something or things like that so
192 P: ((looks towards ceiling and then focuses on middle distance))
193 D: °right°
194 M: We've had a few run ins with her ((nods)) this year ((re settles in chair)) belie:ve me
195 D: Ok :
196 M: Like a couple of like weight problem things like she's been saying things about his weight but (.) she said that its (.) come out in the wrong text like you know =
197 D: °the wrong context°
198 M: =Like the kid is saying this but she's saying something else so cause she called him a blob like that in the library one day
199 D: ((looks towards[patient; slight conspiratorial shrug))
200 P: [((looks towards doctor; slight smile; mirroring conspiratorial shrug))
201 M: Plus then the other day it was something to do with calories and and she said oh no what I said was (.) they'll be burning up calories and he's using his brain whereas he come home and said [that she said that he had to lose some calories and start using his brain
202 D: [smiles and turns gaze back to the computer]
203 M: So um I don't know so ((chuckles)) we've had a few issues with her this year (.) so um=
204 D: = Exercise ((directs gaze to patient) lots and lots of running around and lots and lots of sleep
205 P: ((nods))
206 D: It's going to make you a big tall boy
207 P: ((nods; slight smile))
208 M: ((nods as directs gaze to son and then to doctor))

At turn 187 the mother aligns with her son to offer the doctor a restatement of his answer to her question. Matthew and two others have been singled out as targets for the teacher's bullying. At turn 188 the doctor acknowledges this co-constructed joint response.

But the mother then goes on to speak from an independent position as she puts forward her own increasingly detailed accounts of the patient's difficulties with his teacher. At turn 189, she extends her previous utterance to explain the reason for the teacher's bullying. Matthew and his friends are "not real brilliant". At turn 191 she elaborates further, bringing into the discourse a story of her son's almost daily recounts of distressing incidents at school. Across this sequence Matthew displays increasing

discomfort at these disclosures from his life world. At turn 190 his embarrassment is evident as he averts his gaze to focus on the corner of the desk. At turn 192 he retreats further from the interaction, directing his gaze towards the ceiling and then finding a focus in the middle distance in an attempt to withdraw into 'a private interactional space' (Beach & LeBaron, 2002, p. 627).

Figure 16 : Retreating into a private interactional space (turns 190, 192)

Clearly the doctor is monitoring these subtle signs of the patient's unease. At turn 193 she displays her awareness of the delicacy of the mother's disclosures with a sotto voce news receipt. At turn 195 'ok:', realised with falling intonation, functions to acknowledge and receipt the mother's information. But it is also an attempt to bring the sensitive topic of 'run- ins' with the teacher to a close.

This attempt however is unsuccessful. Across turns 196, 198, 201 the mother elaborates, with illustrations and reconstructions of confrontations with the teacher over the face sensitive issue of Matthew's weight. These 'constructed dialogues'(Tannen, 1989) that reverberate with the teacher's words, vividly invoke face threatening encounters from Matthew's life-world. In light of this, and conscious of face, the doctor moves strategically to align empathically with him.

At turn 199 she directs her gaze towards Matthew in order to regain his attention. Then, with a slight conspiratorial shrug, she displays a light hearted, dismissive stance towards the topic of the teacher and her derogatory remarks to obtain the patient's fleeting smile and mirroring shrug in response (turn 200). As LeBaron and Koschmann point out, such 'jointly employed symbolic forms' (2003) accomplish and display participants' alignment with each other. With jointly produced shrugs, doctor and patient align to

make light of the mother's account. For a brief moment they enter into a subtle fleeting coalition that excludes the mother and functions to strengthen rapport between them.

Note also how the doctor resists aligning with the mother. Constructed dialogue is "primarily the creation of the speaker rather than the party quoted"(Tannen, 1989, p. 99), and in speaking the teacher's words the mother is also speaking for herself. Her vivid reconstruction (turn 201) is infused with her own indignation at the teacher's behaviour and seems to invite the doctor's comment, judgement and coalition. But further elaboration on the topic of the teacher is unlikely to be clinically or therapeutically useful at this point, and the doctor does not choose this path. Rather, at turn 202, with a momentary smile that acknowledges the mother's perspective, she redirects her gaze towards the computer in a move that is intended to bring this topic to a close. The mother responds to this signal with a summarising coda (turn 203) that marks completion of her extended account.

The doctor's next move is decisive. At turn 204, through the direction of her gaze, she selects Matthew as recipient of management advice. Exercise, she asserts, glossed informally as 'lots and lots of running around', together with lots of sleep, will assist him to manage his health. Thus she accomplishes a shift to a frame of practical action that will take the consultation towards its conclusion. At the same time she positions Matthew as a person of growing maturity and autonomy who is able to take some responsibility for his own well being. This position is nurtured as the consultation moves to a close.

6.3.3.6. Fostering autonomy

In the final phase of the consultation, in a variety of ways, Matthew is constructed as an independent and autonomous patient. Consistently, the doctor selects him as recipient of significant management information and advice, such as when to attend for a follow up appointment. Whilst the mother aligns with her son to receipt this information with nods and minimal acknowledgments, the doctor's turns are unambiguously patient directed (See turns 289-295 of full transcript). Significantly, whilst his mother is selected as recipient of preparation procedures for the ultra sound he is about to undergo, Matthew

is identified by the doctor as the party who will be notified of test results. (See turn 279 of full transcript).

Further, he is positioned as a responsible partner in the clinical process of confirming the doctor's provisional diagnosis of anxiety related pain. A few turns later the doctor enlists him to the task of keeping a diary so as to monitor the occurrence of his symptoms.

Extract 7. Consultation 4

296	D:	Ok but ah keep a diary of when you get the pain :
297	P:	((nods))
298	D:	((sustains gaze on patient's face)) A very easy way of keeping a diary is just getting a calendar or a diary and just drawing a face on it if you have got pain maybe draw a sad face on it so you know which days you're having pain (.) and we may be able to correlate that to [specific events =
299	P:	[((nods))
300	M:	((looks towards patient))
301	D:	= Or other things
302	P:	((nods))

Note the doctor's shift in register (turn 298). By modulating from the more childlike semiosis of drawing and faces to the more technical and scientific register of correlation she accomplishes a shift to a more symmetrical relationship with the patient. By modulating to a professional voice, she orients towards Matthew as a mature patient rather than as a child. Note also her choice of the inclusive pronoun form 'we' that arguably constructs Matthew as her collaborator in the clinical process of seeking a correlation between his symptoms and specific life-world events.

Across this sequence the mother orients towards her son as the party who has been selected by the doctor to carry out this task. She offers no vocal or non vocal acknowledgment that would position her as 'unaddressed recipient'(Goffman, 1981) of the doctor's turn or as a partner in keeping the diary. Rather, as she directs her gaze towards the patient (turn 300) she orients towards him as the sole recipient of the doctor's talk and as the person responsible for monitoring his own pain. With assenting nods (turns 209, 302) the patient takes up the responsibility that has been entrusted to him.

6.4 Summary of analysis and coda to analytical chapters

This challenging PBA consultation has been analysed against the backdrop of examiners' evaluations of the doctor's performance on the parameter 'communication and rapport', and with institutionally ratified principles for communicating with adolescent patients in mind. The examiners' ratings represent the responses of two experienced practitioners to the video-recorded interaction that they have observed. But these broad, global ratings cannot offer insight into the on-going interactional work that this doctor does in order to engage the patient in talk, to develop rapport, to engender his trust, and to nurture his development towards autonomy. Further, the multi-party nature of this case goes unremarked in examiners' evaluations. Yet, as close analysis of the discourse has shown, the triadic structure invests the consultation with additional interactional complexity that demands much of the communicative expertise of the doctor. It provides this reticent patient with an avenue of retreat from the interaction and it allows for coalitions to form between mother and doctor that might exclude the patient. The communicative expertise of this doctor lies in part in her ability to acknowledge and draw upon the mother's clinically useful but potentially face threatening accounts whilst at the same time engaging with this novice patient, building rapport and a relationship of trust, and preparing him to take up his role as an independent patient into the future. Discourse analysis directs attention to some of the previously unnoticed communicative 'know how'(Ryle, 1949) that this doctor deploys as she manages triadic interaction in pursuit of her relational and clinical goals. As with other PBA consultations examined for this thesis, discourse analysis makes available for examiners to see, in all its detail and complexity, the discursive work that has prompted their judgement of the candidate's communicative performance.

Throughout this study, analysis of PBA consultations has been carried out in light of those principles, guidelines, and theoretical models that General Practitioners draw upon as they teach, evaluate, and talk about clinical communication. Attention has been directed towards how principles of autonomy and trust are interactionally accomplished (this Chapter), and how models such as the model of empathic communication (Chapter 4) and the stages of change model (Chapters 5) actually play out in situ in specific challenging clinical situations. The accomplishment of salient themes that circulate in the discourses of General Practice, specifically empathy, rapport, and finding common

ground, and their interplay in shaping the direction of the interaction, has been a particular focus of attention.

The study has provided much evidence that communicative expertise, as displayed in the challenging consultations under analysis, takes practitioners well beyond the simple direct application of espoused models and guidelines, or the simple replication of pre-conceived skills and exemplar phrases in the manner that communication guidelines and text books suggest. Rather it consists in developing the capacity of doctors to draw strategically and creatively upon a rich resource of language, discourse and other semiotic means so as to respond purposefully to the moment as interaction unfolds in ways that both attend to the therapeutic relationship and advance the trajectory of the consultation and the mutual purposes of the participants.

In this chapter, for example, patient autonomy and doctor-patient trust have emerged gradually as outcomes of continuing interactional work. Through the doctor's strategic actions, including gaze direction, bodily orientation and choice of address terms, participation frameworks are configured and reconfigured and relationships between doctor, patient, and mother are realigned. In this way the patient is gradually repositioned from an initial relationship of interactional dependency on his mother to one of increasing independence where he is expected to speak for himself, and ultimately to one of responsibility for monitoring his own health.

Trust between doctor and patient, in the sense of a trusting therapeutic relationship in which the patient feels confident that he or she will not be embarrassed or judged, is also a cumulative accomplishment. It builds gradually as an outcome of strategic discursive choices on the doctor's part that realise empathy and strengthen rapport. Discourse analysis directs attention to the doctor's constant monitoring of the patient's bodily responses to potentially face threatening disclosures about him and her reflexive empathic actions in response. Through such empathic actions at critical moments throughout the consultation, the doctor displays to this adolescent patient her non-judgemental understanding of his troubles at school and her recognition of the legitimacy of his claims of pain. Analysis has also made visible actions that function to strengthen rapport between doctor and patient. For example, at face threatening moments the doctor aligns with the patient to take up an affiliative and sympathetic

stance in relation to the teacher that diffuses the patient's embarrassment. In such ways she gradually constructs an interactional environment of mutual trust and non-judgemental acceptance where potentially face threatening topics are put into perspective as matters that might be safely aired and addressed.

Similarly, in those other crucial sites examined for this thesis, communicative expertise has been found to consist in constant, strategic interactional work that is locally responsive as it moves the consultation in productive and clinically useful directions.

Chapter 4 set out analyses of two consultations involving patients' hidden concerns. In the first of these consultations, the doctor's sensitive choice of expert empathic formulations, resonant with the patient's unvoiced emotions, and in concert with gaze and body orientation, occasioned a gradual shift from presenting concerns that were bio medical in nature towards disclosure of the delicate matter of debilitating anxiety and depression. In contrast, in the second, formulations functioned selectively to direct attention away from emotional concerns of potential clinical significance towards bio-medical matters.

Chapter 5 traced the step wise accomplishment of a measure of common ground between doctor and patient in a lifestyle change consultation where the doctor's clinical objectives were constantly diverted by patient dissent. Through strategies that included invoking overlaying frames of banter and wry humour, doctor and patient collaborated to sustain rapport and to maintain a viable therapeutic relationship despite underlying dissent. But communicative expertise lay also in the doctor's forward-moving proactive management of conflict. In a variety of ways, she worked proactively to make use of dissonance as a resource so as to advance the trajectory of the consultation. For example, in responding to conflict by inviting the patient to display his perspective she was able to gain insight into his thinking. In this way the patient's perspective became a resource that the doctor drew upon strategically as she pursued her objective to persuade him of the need for lifestyle change.

The Discourse of the General Practice consultation has emerged in this study as complex, creative and co-constructed. Within the constraints of a purposeful, goal-directed and institutionalised activity type, doctors, patients and sometimes

accompanying parties as well, construct interaction afresh in the here and now as they pursue their purposes, respond to each other, and address dilemmas as they arise. Communicative expertise is displayed through the doctor's discursive choices in specific local interactional contexts, rather than through recourse to pre-conceptualised phrases or skills. It lies in the ways practitioners deploy language and other ways of meaning, sometimes routinely, and sometimes in unexpected and creative ways that push the boundaries of the Discourse, in order to construct and sustain effective therapeutic relationships as they work towards clinical goals.

As I bring this thesis to a close I wish to consider the question of the practical relevance of analytical findings for practitioners. The study has made visible the complexity of expert clinical communication in a small number of single case studies representing specific, crucial communicative sites that have been identified as particularly communicatively challenging by participating practitioners. How might descriptions of interactional processes in these uniquely co-constructed encounters be of value to medical educators as they prepare and support registrars to communicate effectively in the wide range of clinical situations that arise in practice? Might findings from the study also be of value to examiners as they evaluate communicative expertise?

Ultimately, it is for General Practitioners themselves to appraise the relevance of findings and to determine what is applicable to their work. As Roberts and Sarangi point out in various places (1999a, p. 498, 2003), knowledge generated through research into professional communication needs to be re-contextualised in a reflexive way by practitioners themselves. Nevertheless, the final chapter offers suggestions for how results from the study might be made relevant to the profession of General Practice, and how the practice of discourse analysis more generally might contribute to the teaching of clinical communication, but also to its evaluation.