5

The context of treatment decision-making in HIV

> Contexts are partly outside of the discourse or text, but at the same time the discourses and their relevant contexts constitute each other ... Discourse and context are brought into being as complementary aspects of the same sense-making processes.
>
> (Linell 1998:144)

> ..to hear something as inappropriate, aggressive, persuasive is to relate grammar, meaning and context. (Hasan 1996: 111)

5.1 Aims of this chapter

In Chapters 1 and 2, I outlined some of the limitations of the dominant model of styles of medical decision-making, in which shared decision-making is seen as a mid-point on a cline between paternalism and informed choice. Stretched between these poles is an abstract space representing variation in one particular social process, namely medical decision-making. It was suggested in Chapter 2 that this abstract space might be better represented as multi-dimensional. Shared decision-making (SDM) could then be understood as a particular type of social practice which differs from other styles of medical decision-making across a *number* of dimensions. In chapter 3, I suggested that it was possible to relate such a multidimensional abstract space of variation in medical decision-making to the 'meaning space' by which other social practices might be characterised, locating SDM in its broader social environment. Chapter 3 also suggested that the systemic functional model of

language-in-context provided a useful way of framing this variation as variation in *meaning potential* at different orders of abstraction, so that claims about shared decision-making as a specific type of social practice or context, could be grounded in a discussion of particular verbal practices. In chapter 4 I argued that one of the most important areas of meaning potential which distinguishes shared decision-making from other types of medical decision-making practice is the construal of agency, but that its realization in interaction is dispersed, partly over these different levels of abstraction or strata. The present chapter focusses on shared decision-making from the perspective of its 'contextual parameters' of meaning, identifying ways in which agency and other crucial dimensions of the meaning potential of shared decision-making are organised at this level. Two very different instances of shared decision-making are analysed in terms of their key contextual parameters, and in terms of how such parameters cluster into phases of decision-making, to show what this means in practice for doctors and patients in HIV medicine.

5.2 Treatment decision-making styles and meaning potential

Meaning potential refers to the range of significant variation that is at the disposal of a speaker or a discourse community (Halliday 1973). Viewed from the perspective of lexicogrammar, meaning potential represents what a speaker can say. Viewed from the semantic perspective, meaning potential represents what a speaker can mean. From the perspective of context, meaning potential represents what members of a culture can achieve through their semiotic action. Meaning potential is an elastic space, and the stipulation "within a culture" is not intended to preclude cultural change and fluidity. However, it is within its *context of culture* that each context of situation has its particular significance. For instance, where a medical context is understood as inherently a scientific context, and distinct from a religious contexts, this understanding must be seen as a relation between the context of situation and the context of the broader culture within which the situation takes place. In some

cultures[1], of course, a medical context may be typically and inherently a religious context.

All instances of social interaction will fall somewhere in this abstract space of meaning potential. Different instances of any one recognised type of interaction, such as shared decision-making, will tend to cluster in the same general area. By being systematic about the relevant dimensions of SDM – i.e., by describing how it is both like and unlike other forms of social process and interaction – it is possible to clarify the meaning potential of SDM vis-à-vis other styles of decision-making, and to plot their relation to each other in this abstract space. We can also see how SDM might in some respects resemble, and in others differ from, social practices beyond doctor-patient interaction, including other professional contexts, such as relationship counselling or legal mediation. Perhaps more importantly, it should be possible to suggest why it is that a certain wording might in one place seem to contribute to SDM, but in another place in the same consultation, or in a similar consultation, seem to constitute something that is the antithesis of SDM.

Medical decision-making in general is a social context which is likely to fall across quite a broad area of meaning potential, given the economic, ethical, political and historical pressures acting on it at present. In particular, as discussed in chapter 2, the character of decision-making in western medicine varies in the degree to which it construes patients as agents of their own healthcare, and the degree to which it construes alignment between doctors' and patients' views as a condition of adequate decision-making. HIV medicine has been described as area of medical practice which tends to encourage patient agency and doctor-patient alignment (Race et al. 2001, Moatti and Souteyrand 2000). The analytical approach taken in this chapter focusses on how, and how consistently, treatment decision-making plays out as a context which requires patient agency and doctor-patient alignment.

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[1] I include cultural differences not based on ethnic identity. For example, the culture of palliative care in western medicine is more likely than other medical specialist fields to consider the spiritual and emotional concerns of its patients as 'core work'. The fact that there are (at least) two orders of phenomena involved –ie situation/activity and culture – can be seen in current debates about remodelling palliative care in ways which would shift its culture away from valuing spiritual/ psychosocial care (see Arnold 2002).

5.2.1 Language and context: a bi-directional relationship

The cornerstone of this approach is the idea that discourse and context are interdependent phenomena which bring each other into being. This is an important claim which has been reiterated in many accounts of context since the seminal work of Malinowski (Malinowski 1923, Malinowski 1978/1935) and Volosinov (Volosinov 1983/1930). However, many of the implications of claiming that context and discourse mutually realize each other have only recently been brought into close scrutiny. In particular, it has been necessary to problematise the persistent assumption that context *determines* language use, and to show how participants' sense of context is largely *created* through language (Goodwin and Duranti 1992).

Gumperz (Gumperz and Cook-Gumperz 1982) demonstrated that any aspect of linguistic behaviour may function as a *contextualisation cue,* i.e., as a cue to which aspects of the context are relevant in interpreting what a speaker means (Drew and Heritage 1992). More broadly, Gumperz's notion of contextualization cues opens the way to an analysis of context as dynamic (Drew and Heritage 1992) and of context as being in a relationship of mutual realisation with language. In other words, a contextualisation cue helps interactants to decide on their interpretations not only of a speaker's utterance in a particular context but also of the context itself. For shared decision-making to be possible, and for doctors and patients to negotiate their way through particular decisions and into and out of more and less joint styles of decision-making, they must be able to share contextualisation cues in a way which helps them identify the meaning of particular utterances and track their ongoing dynamic negotiation of context. Gumperz's insight, that any aspect of linguistic behaviour may function as a contextualization cue, becomes more powerful if each aspect of linguistic behaviour (in Gumperz's terms, lexical, prosodic, phonologic, syntactic, and code/ style choices) is seen not as a cue in isolation but as part of a suite of features which together cue the context. The analysis below of decision-making as contextual configuration and contextual sequence is an attempt to do this, insofar as working with transcribed audio data allows.

Important insights about the way in which language may create or 'reset' the context have been made within the medical and sociological literature but these still

need to be brought into focus in the kind of dialectic perspective on context and language currently being elaborated within social linguistics and related disciplines. The two key planks of such an approach are:

i) clarifying the contextual *dimensions* along which styles of medical decision-making vary, with reference to the relationship between context and its activation through particular linguistic and interactive choices; and

ii) clarifying the role of the *sequencing* of interactive moves in achieving the configuration of contextual parameters[1] associated with shared decision-making.

I will deal with the dimensions first.

5.2.2 Modelling decision-making styles as multidimensional contexts

To illustrate the multiple dimensions which need to be kept in view when gauging shared decision-making, consider the following treatment decision from my data set. This instance of treatment decision-making presents a challenge to current models of SDM. During the course of Consultation 29, in which a change of antivirals is negotiated, the patient, Neil, has also asked the doctor, Trevor, to examine an anal wart. (Anal warts are a common "opportunistic infection" associated with HIV infection.)

29_136 P However, I did notice that the anal wart that was treated, has returned.
29_137 D That ( ) the wart
29_138 P It's quite annoying actually, I found-
29_139 D Is it?
29_140 P Like yesterday I wiped my arse a bit hard and I actually bled. And I think I might have scraped it or
29_141 D Do you want me to have a look at it, in other words?
29_142 P I would, I would actually, like you to check that out.
29_143 D Okay
29_144 P Just to have a look
[35 turns omitted during which other presenting problems are discussed and observed]
29_189 D Oh, this little thing here?
29_190 P Yeah.

[1] I am using 'parameter' in its mathematical sense to mean a particular value of a particular dimension.

29_191 D Is that what you're worried about?
29_192 P Oh, it's actually you know, some of... it's very irritating.
29_193 D Oh, I'll just paint a little bit of stuff on it.

This excerpt represents an instance of decision-making about treating anal warts, from the doctor's physical examination and observation of the problem reported by the patient, through to the doctor deciding to paint some wart solution onto the area, and his action in providing such treatment in the surgery.

At face value there is little evidence in this excerpt of shared decision-making. The above excerpt *could* be described as an instance of a maximally paternalistic decision-making style, where, in the words of Emanuel and Emanuel (1992), "the physician authoritatively informs the patient when the intervention will be initiated" (in the above example, this is to be done immediately, while the patient is still undressed and on the examination table, giving him minimal chance to refuse or evade an imposed treatment). Or in Charles et al's (1997) terms, the doctor "does what he thinks is best for the patient without eliciting the latter's preferences. Patient involvement (if there is any) is limited to providing consent to the treatment advocated". Such an interpretation would be consistent with the observation that deciding what to do about anal warts does not appear to invoke considerations of equipoise, which has been described as acting as a kind of gateway to shared decision-making: only where clinicians feel that there is no clear best practice, but a number of roughly equivalent alternatives exist[1], are they likely to engage patients in shared decision-making (Gwyn and Elwyn 1999, Elwyn, Edwards, Gwyn and Grol 1999).

But describing this decision as paternalistic would probably strike most readers as problematic, and not very sensitive to the particularities of the context. For instance, it seems unlikely that this patient had this treatment imposed on him against his will. It seems equally unlikely that the patient wanted such a treatment performed, but it was a matter of happenstance that he got what he desired. It also

[1] In my view, equipoise is not so much about the relative equivalence of alternatives, but more about a discourse community's epistemological state with respect to estimates of equivalence. There is a lack of consensus on what "equipoise" means and whether it is a productive doctrine in medical ethics – see, e.g., Lilford (2001).

seems unlikely that the patient was in a *state* of being *uninformed* about the wart treatment, even though he did not undergo a *process* of being *informed* in this particular session. The sense that these options are all wrong can be explained by appealing to evidence from the text that the doctor and patient in Consultation 29 are in an ongoing clinical relationship and that the presenting problem and its treatment have occurred before; and that the patient probably had the opportunity to indicate any relevant preferences in previous consultations. On the other hand, the existence of previous similar consultations does not in itself guarantee that the doctor is not acting paternalistically: repeated episodes may merely reinforce previous unshared choices. How can we generalise in the requirements of shared decision-making in a way which stays sensitive to the particularities of context such as the one illustrated above? The following section outlines the approach taken in my study.

5.3 A multi-dimensional framework: Field, Tenor and Mode

There are a number of different traditions that can provide useful apparatus for situating medical decision-making within the environment defined by alternative forms of decision-making. The apparatus used here is the model of Field, Tenor and Mode, developed and currently being elaborated within SFL (Halliday 1978, 1985, Hasan 1985a, 1995, 1999, 2000, Butt 2000b), drawing on Malinowski (1923, 1978/1935) and Firth (1957). SFL has long had a central concern with drawing explanatory links between the micro-level patterning of interactions at a textual level and the relevant aspects of context (Thompson 1999). It has been a "design feature" of the SFL model of language that it encompasses grammar, semantics and context. Although this inclusion of context as an interdependent stratum of meaning brings a number of problems, and some may argue that it overdetermines the construct of context, the advantages of this approach outweigh the disadvantages for my purposes because of its ability to bring many relevant phenomena to bear on each other within one overall frame.

In its earliest guise (Malinowski 1923, 1978/1935), the notion of context as it is used here was oriented towards supplying details of concrete situations in the Trobriand Island culture that could not be captured in the translation of the texts

which accompanied or constituted them, so that it might be possible for speakers of the target language to understand the texts. From this concrete approach a critical move towards a more generalized account of context was made by Firth, who identified abstract categories which co-ordinate context and meaning for the purpose of building a sociologically oriented general theory of linguistics rather than providing situational commentary on specific texts (Firth 1950, Halliday 1985). This approach received early empirical application by Mitchell on the 'language of buying and selling' in North Africa (Mitchell 1957/75); similar approaches drawing on the work of Malinowski and Jakobson (1960) were developed within what could broadly be termed linguistic anthropology (Hymes 1967, 1974, cf. Duranti 1997). Firth's abstract categories were abstracted somewhat further by Halliday, reappearing as the 'conceptual framework' of Field, Tenor and Mode, and related in turn to the Experiential, Interpersonal, and Textual functions of language (Halliday et al. 1964 ch 4). Such a framework serves to "interpret the social context of a text, the environment in which meanings are being exchanged" (Halliday 1985: 12), or as Hasan (2000) puts it, with apologies to Fishman, "who says what to whom, where when and how"[1].

Some basic definitions: the notion of FIELD of discourse provides a way of describing the social action that is taking place. The notion of TENOR of discourse refers to the role relationships that obtain among the participants. This includes both the types of speech role they are taking on in the dialogue, which can be very temporary roles (such as speaker and addressee), along with the whole cluster of socially significant relationships, including more permanent roles and categories (e.g., gender and generation). The notion of MODE of discourse refers to what part the language is playing in the situation. It includes highly interpretive aspects, such as the participants' expectations of the effects of their language, and also the less interpretive aspects of channel and medium.

I will discuss limitations of this model at appropriate points later in this chapter. For the moment, I will proceed by exploring how the conceptual framework of Field,

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[1] Hasan also renames the three features Action, Relation, and Contact, in a recent application of her theory (Hasan 2000).

Tenor and Mode can help to characterise SDM, and can help to identify and remedy some limitations in the current modelling of SDM.

Recent developments on the construct of context within SFL, in particular Hasan (1995, 1999) and Butt (2000b), have pushed the framework away from the identification of "raw categories" of experience by which one might label a particular interaction, and towards a more generalised "parametric" approach – a kind of deconstruction of participants' typifications. So instead of yielding descriptions which are largely labels for the situations themselves, such as "medical consultation; between the patient, his partner, and a GP; conducted through the spoken medium, largely face to face", there has been a push towards describing the underlying dimensions by which such categories may be generated and/or recognised by members of a culture. This is a useful move from the point of view of research on emerging/evolving social processes such as SDM, and for considering the potential directions in which such processes might evolve, because the parametric approach provides a way of establishing both what is unique and what is shared between different contexts. This move can be seen as a change in focus from the "instance" to the "system" (Butt 2000b), drawing on the notion of the "cline of instantiation". To take a concrete example: it does not do to merely specify the agentive roles as "doctor" and "patient" and then argue that a hierarchical relationship follows from this categorisation. Hasan (1985a) supports a hierarchical description of vendor and customer relations in general on the grounds that vendors must solicit their services. But this does not work, because it is not necessarily inherent in the vendor/customer relationship that the soliciting party has the subordinate role: witness the complexities of situations such as arranging a bank loan and buying an expensive sportscar.

For medical interactions, the field might be described as a context of care, specialised rather than quotidian, but having elements of economic transaction. This allows for a potential calibration between the everyday, nominal description of context (e.g., a treatment decision about antivirals) with a linguistic-theoretical description. Such calibrations serve as a partial explanation of the context-meaning-lexicogrammar relation, and as a prediction of how it may evolve. That is to say that by observing and interpreting the contextual "make-up" of treatment decisions and

the processes by which they are made, we can more fully ground our reasoning about how a certain kind of strategy, such encouraging patients to ask more questions, might enhance shared decision-making, or might fail to do so.

This parametric approach to describing context remains interpretive, but becomes explicitly and consistently contrastive. A contrastive approach to modelling context is essentially an extension of Saussure's model of language, in which the meaning of an item is a function of its difference from all the other items in its system of relations (Saussure 1959/1919). Arguably, just as the meaning of the sound of a word lies in its contrast with the sounds of other words, the meaning of a situation is based on contrast with other situations. Such an approach is useful for comparative analysis, since it provides a series of simultaneous dimensions of contrast with which statements can be made about each instance of decision-making, about sections of decision-making discussions, and about whole corpora. As Sarangi and Clarke point out (2002: 299, citing Garfinkel 1981), in a contrastive explanation "what gets explained is not simply 'why this', but 'why this rather than that'". In this article on genetic counselling, domains of contrast are of interest to Sarangi and Clarke primarily because interactants use contrasts as organising decision-making structures. They show how the invoking of local contrasts often substitutes for directly declaring a recommendation. The importance of *local* contrasts of this type will be explored in chapter 6. In this chapter, my focus is on sets of contrasts which are more pervasive across doctor-patient interactions globally. These contrasts are typically not invoked by participants as criteria by which decisions will ultimately be made, but they shape the way in which decisions are made – for instance, a context is seen as one in which professional direction is appropriately given and taken as advice, or not.

It might be helpful to consider an example to illustrate the idea of global contrasts. In his study of grammatical and social agency in Samoa, Duranti (1994) shows that representing social actors as grammatical agents, using ergative marking available in Samoan, serves purposes of praising and blaming in two very different contexts – the formal, ritual context of the village fono, and the everyday context of casual conversation. Duranti notes that in the fono access to using agentive

representations is restricted to particularly influential public figures, whereas it is open to anyone in other contexts (though there may be ramifications attached to using it). Such differential access suggests a pervasive, global contrast between these two types of contexts in terms of Tenor – a contrast which shapes the nature of interactions whether it is appealed to in a particular interaction or not. Moreover, contrasts such as whether access to a certain semantic strategy is open or restricted are essentially what *constitutes* the context of the everyday versus the context of the fono; they are not merely determined by it (cf. Goodwin and Duranti 1992; Cicourel 1973). (Material settings are of course essential too, such as the use of particular buildings, rooms, and seating positions; these can be considered part of how the abstract contextual configurations are realized, along with linguistic and other realizations.)

The specific sets of contrasts which I use to describe contexts of decision-making, largely follow Butt (2000b), which in turn elaborate/interpolate the Field network of Hasan (1999). Note that within each network (Field, Tenor, Mode), the choices are grouped into what Butt (2000b) calls domains of contrast. Conceptually, this analysis is an attempt to synthesise a number of central theoretical and empirical insights of sociology, psychology and related disciplines that tell us how people respond to aspects of their environment as "context" or "situation" (see Argyle et al. 1981), with an increased emphasis on the co-patterning of these phenomena with language. From this perspective the networks presented by Butt (2000b) and Hasan (1999) also represent considerable amounts of empirical observation and interpretation of textual and contextual data. The networks represent a kind of "grounded theory" (Strauss and Corbin 1994) of the relation between context and text across settings as varied as caring for young children (e.g., Hasan 1999, 2000), formal education (Butt 1996, in press), medical interaction (Brown et al. in press, Butt and Moore 2002), disability care (Butt et al. 2002a, 2002b), and verbal art (e.g., Butt 1988a, 1988b).

The network method of conceptualising and displaying the choices available and the choices taken draws directly on the notion of meaning potential as an abstract space. The space itself is a "analogue continuum" (Thibault 1997: 61-62), and although the network diagrams appear to set out only categorical choices, this is

largely a convention, since node labels are necessary to indicate each dimension of contrast in the network. Thus networks set out contrasts which in actual discursive practice need not be "rigidly either/or" (van Leeuwen 1996: 72). According to Saussure, difference itself "admits of degrees" (Saussure 1994/1878: 77, cited in Thibault 1997: 61). In addition, boundaries may be deliberately blurred, and contrasting categories may appear simultaneously in a way that marks phasal movement from one context to another from a logogenetic point of view, or marks interdiscursive links between existing or evolving contexts from a phylogenetic perspective (cf. van Leeuwen 1996). Indeterminacy is not an aberration but a 'normal and necessary feature of an evolved and functioning semiotic system" (Halliday and Matthiessen 1999: 547).

As diagrams, then, the context networks used here are partially iconic, with spatial distance between different items representing difference in meaning but only up to a point. Since the networks are two-dimensional, a number of arbitrary spatial associations and dissociations are also necessary. The networks should be read as setting out difference across the vertical space within each domain of contrast. For instance, within the domain of contrast material action, the option *obligatory material action* represents one plottable area of meaning potential; *absent* material action represents the meaning potential that is furthest away from obligatory material action; and *oblique* material action is somewhere between the two points in the meaning space, as shown in figure 5.1 below.

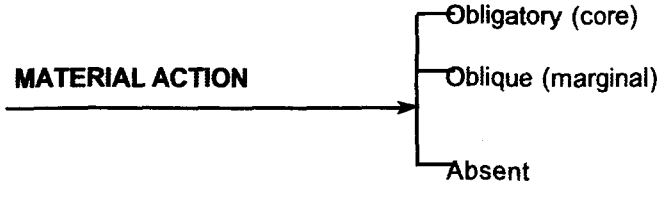

Figure 5.1 Primary choices in a domain of contrast (material action)

More delicate (detailed) contrasts within these broad contrasts are distributed across the horizontal axis. Figure 5.2 shows further distinctions in contrast within the meaning space of *absent material action.* Material action may be absent in the sense of being *irrelevant* to the activity taking place; or material action may be absent but germane – the activity in question may be shaped by a *deferred* material action. Medical decision-making with respect to antiretroviral treatment (HAART) is such a field. The nature of the activity of decision-making is shaped in part by the foreshadowed action of taking pills. The settings for such a field are shown as the boxed options in Figure 5.2.

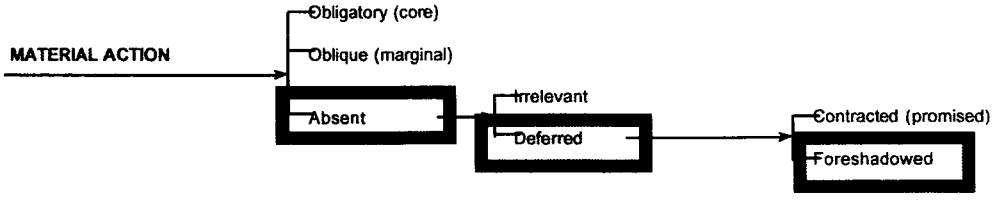

Figure 5.2 More delicate choices in a domain of contrast

In FIELD we need to consider four lower-order domains of contrast, namely SPHERE OF ACTION (contextualises the subject matter); MATERIAL ACTION (specifies the role of physical action in the context); ACTION WITH SYMBOLS (specifies the role of semiotic action in the context); and GOAL ORIENTATION (deals with timeframes and overtness of goals, and the degree to which there are multiple and/or disparate goals in play). In TENOR there are also four domains, namely SOCIAL HIERACHY (the status/power relations between participants and whether they are variable); AGENTIVE ROLE (how the actant role is achieved and through what institution, and whether it varies during the interaction); SOCIAL DISTANCE (particularly the extent to which participants can be expected to have shared or distinct codes); and Network Morphology (mapping the participants' social

network into the description of Tenor). In MODE there are three, the ROLE OF LANGUAGE (is it constitutive of the activity or ancillary to it, or somewhere in between); CHANNEL (which specifies the signal type); and MEDIUM (which specifies organisational aspects which may or may not be congruent with the actual channel – e.g., when the doctor talks and writes in the patient record, it comes to the patient's ears as speech signal, but with some of the features typical of written language). For reasons of space, the contrasts within each of these domains will be discussed and interpreted through demonstration, i.e., as they are brought in to describe the present data.

5.4 Interpreting Field, Tenor and Mode as decision-making styles

5.4.1 A shared decision about wart treatment?

Returning to our decision-making example from Consultation 29 (Trevor and Neil), we can characterise this stretch of interaction in terms of the Field, Tenor and Mode settings it evinces, and see which features are shared with other instances of decision-making from the present corpus, and the degree to which such features seem to represent shared decision-making or other styles. The Field, Tenor and Mode descriptions of this decision about wart treatment instantiated in Consultation 29 are presented in Figures 5.3, 5.4 and 5.5, below the commentary.

29_136	P	However, I did notice that the wart that was treated, has returned.
29_137	D	That ( ) the wart
29_138	P	It's quite annoying actually, I found-
29_139	D	Is it ?
29_140	P	Like yesterday I wiped my arse a bit hard and I actually bled. And I think I might have scraped it or
29_141	D	Do you want me to have a look at it, in other words?
29_142	P	I would, I would actually, like you to check that out.

29_143 D Okay
29_144 P Just to have a look
[35 turns omitted during which other presenting problems are discussed and observed]
29_189 D Oh, this little thing here?
29_190 P Yeah.
29_191 D Is that what you're worried about?
29_192 P Oh, it's actually you know, some of... it's very irritating.
29_193 D Oh, I'll just paint a little bit of stuff on it.

FIELD

In terms of field, the above excerpt can be described as the diagnosis and treatment of anal warts co-occurring with HIV infection. Under a contextual parameters approach, this description can be made more delicate and more contrastive. In the domain of contrast SPHERE OF ACTION, this context involves a complex relation of *specialised* and *quotidian* spheres of action. It is everyday in the sense of being *routine institutional practice*, in a context that is well *established* rather than novel for both the doctor and the patient. These aspects of the context are brought out in such features of the verbal component of the interaction as the reference to previous episodes through exophora, the low level of facework and information preliminary to the patient's request for an examination, and similar features in the doctor's response.

At the same time it is a specialised context where, for the doctor, participation is recognised as being possible only by professional accreditation, which involves considerable study and training. In this case the phenomena involved are largely *sensible* (available as sensory stimuli) rather than *intelligible* (available only to the intellect), hence the activity undertaken at this point involves the 'clinical gaze' with its distinct roles of D as actor/senser and P as goal/phenomenon.

In this episode, MATERIAL ACTION is *obligatory,* whereas ACTION WITH SYMBOLS is *necessary* but minimally so and oriented towards *guiding* material action rather than *telling* (in the sense of using symbolic action, in this case language). This contrasts with discussions of antiviral treatments, where conceptual symbolic action is the core of the activity, and the phenomena involved, principally

viruses and the measurement of their activity as "viral load", are not *sensible* even to the trained clinical eye, but require complex symbolic/technological mediation[1]. Compared with discussions of viral load, the less technologically sophisticated spheres of action, perhaps paradoxically, tend to exclude patients from the role of semiotic agent. In Neil's case here, there is the added factor that the warts are located in a difficult place for him to observe, thus further positioning him as material object for the duration of the wart episode.

Finally, GOAL ORIENTATION in this episode is relatively immediate, singular, and non-contentious: thus, it has a high level of what Hasan describes as goal visibility (Hasan 1999). This episode contrasts with HAART decisions, where the temporal and phenomenological horizon encompasses the patient's whole life, and where the goal(s) of treatment are not always clear, uncontentious, or shared between doctor and patient. Note that where the goal of the activity is visible and uncontentious – e.g., the eradication of visible and palpable wart tissue – this goal is not spelled out by the either the doctor or the patient. It is inferred as *defined by the activity* itself, at least partly, rather than declared in a *coded form.*

The notion of Goal in modelling behaviour and context is an inherently difficult one, since it may be taken to imply that social actors are conscious of their motivations and act in response to them, and analyses based on the notion of goal have tended to conflate motivation with outcome (Hasan 1999; cf. Erickson 2001, Sarangi and Candlin 2001). Thus it is important to shift the analytic focus away from nominating the goals themselves. Instead, the focus should move towards:

a) examining how the degree of goal complexity and visibility might render the activity's shape and success vulnerable and variable, requiring more time, effort and allocation of symbolic resources to the task of inferring, negotiating and, where appropriate, integrating goals; and

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[1] See Appendix 6.2 for extended discussion.

b) considering goal orientation not only as a property of individual speakers but also as a property of social groups and cultures: in an important way the goal orientations of social activities are expressed in their character, or what Hasan describes as their design (Hasan 1999).

TENOR

In terms of SOCIAL HIERARCHY, there is some evidence of different orders of power in this interaction, although the difference here is best construed in terms of specific 'power to' rather than general 'power over'. The patient has the power to request/direct clinical attention to a particular phenomenon; the doctor has the power to respond swiftly and independently with treatment. Thus the power/status roles are *hierarchic* but *mutable,* and largely *uncoded.* The AGENTIVE ROLES and their relations are *civic*, deriving from both *office* and *status*, and *reciprocating: complementary* (the complementary agentive roles are a congruent link-up with the mutable nature of the hierarchical relations described above).

Perhaps the most dominant feature of this context is the SOCIAL DISTANCE between the participants. In this short episode there is considerable evidence of shared coding with respect to technical fields, though the code that is shared is non-technical and informal – e.g., where the doctor uses the highly generic lexical item "stuff". Such coding orientations can also be interpreted as evidence of *weak classification* between contexts (viz, over the counter wart self-medication cf. physician-administered treatment) and possibly of *weak framing* (viz, it is not a high priority to be concerned about whether "stuff" is a permitted way of speaking about treatment, or whether it is an appropriate term for a doctor to use). In addition there is ample evidence of shared local history: the participants' engagement in this context or ones very similar to it is a *recurrent* phenomenon. (There is however little evidence to bring to bear on the question of whether Neil and Trevor belong to a social network that extends beyond the clinic, or have multiplex relations.) It should

be stressed that social distance is understood here as primarily as a quality of the interaction that is largely achieved through the *process* of interacting, similar to Aronsson and Sätterlund-Larsson's (1987) notion of "social choreography" in medicine, not just as a fixed determinant of the nature of the interaction, although to a certain extent it is that too (cf. Cicourel 1973).

The above analysis has an immediate pay-off. The evidence of a particular Tenor in the wart episode can be taken into account in considering whether this episode counts as an instance of paternalistic decision-making. I would argue that it counts against such an interpretation, since the evidence suggests that this is a case of the communicative reduction of explicitness that comes with intimate relationships of various kinds (cf. Cicourel 1973, Brown and Levinson 1987). Patients and doctors might feel it highly inappropriate to become explicit about matters that have long been assumed to be shared, since introducing such explicitness would re-set fundamental aspects of the ongoing Tenor established through the relationship's developments – cf. Garfinkel's trust experiments (Garfinkel 1967).

Of course caution must be maintained against doctors assuming they know what their patients think or want just because they see each other regularly, and some research suggests that when interactional moves such as requests for clarification are avoided in order to avoid breaking down intimacy in doctor-patient relations, this can be at the expense of shared understanding between doctors and patients (e.g., Aronsson and Sätterlund-Larsson 1987). In any case, the key point for the present discussion is that there are opposing forces at work which make shared decision-making and explicitness often mutually incompatible.

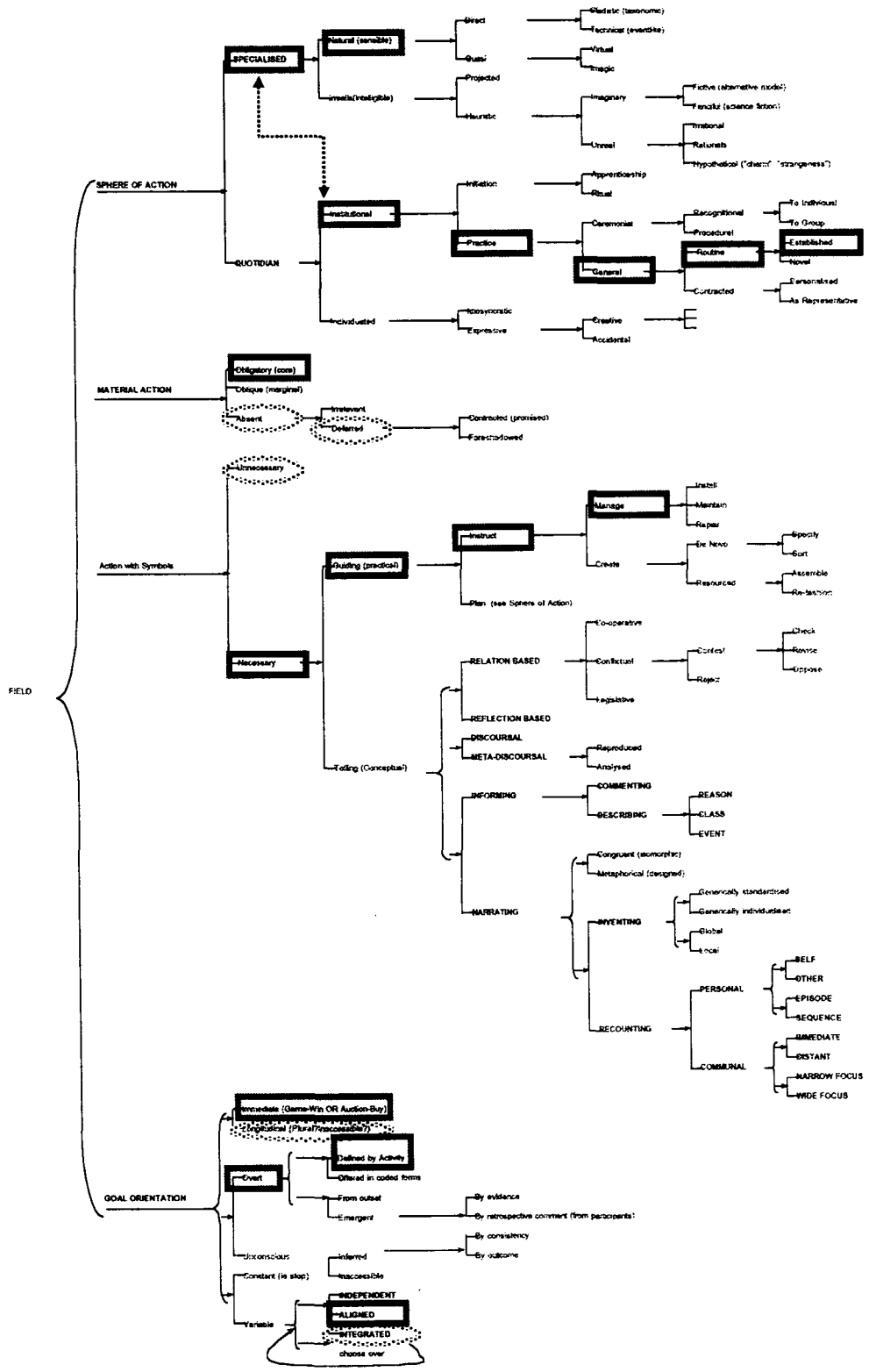

Figure 5.3 Field settings for Consultation 29a (wart treatment episode)

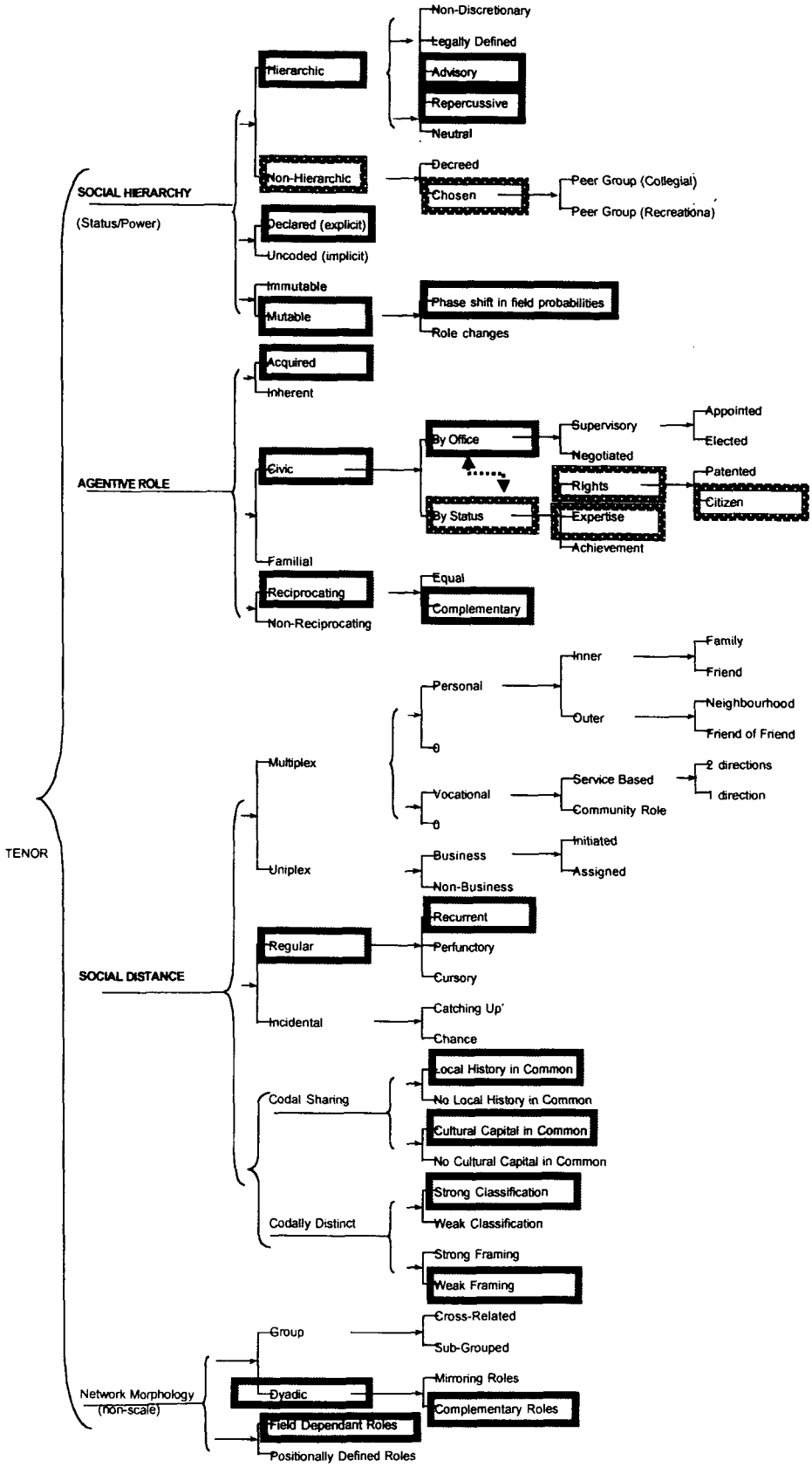

Figure 5.4 Tenor settings for Consultation 29a (wart episode)

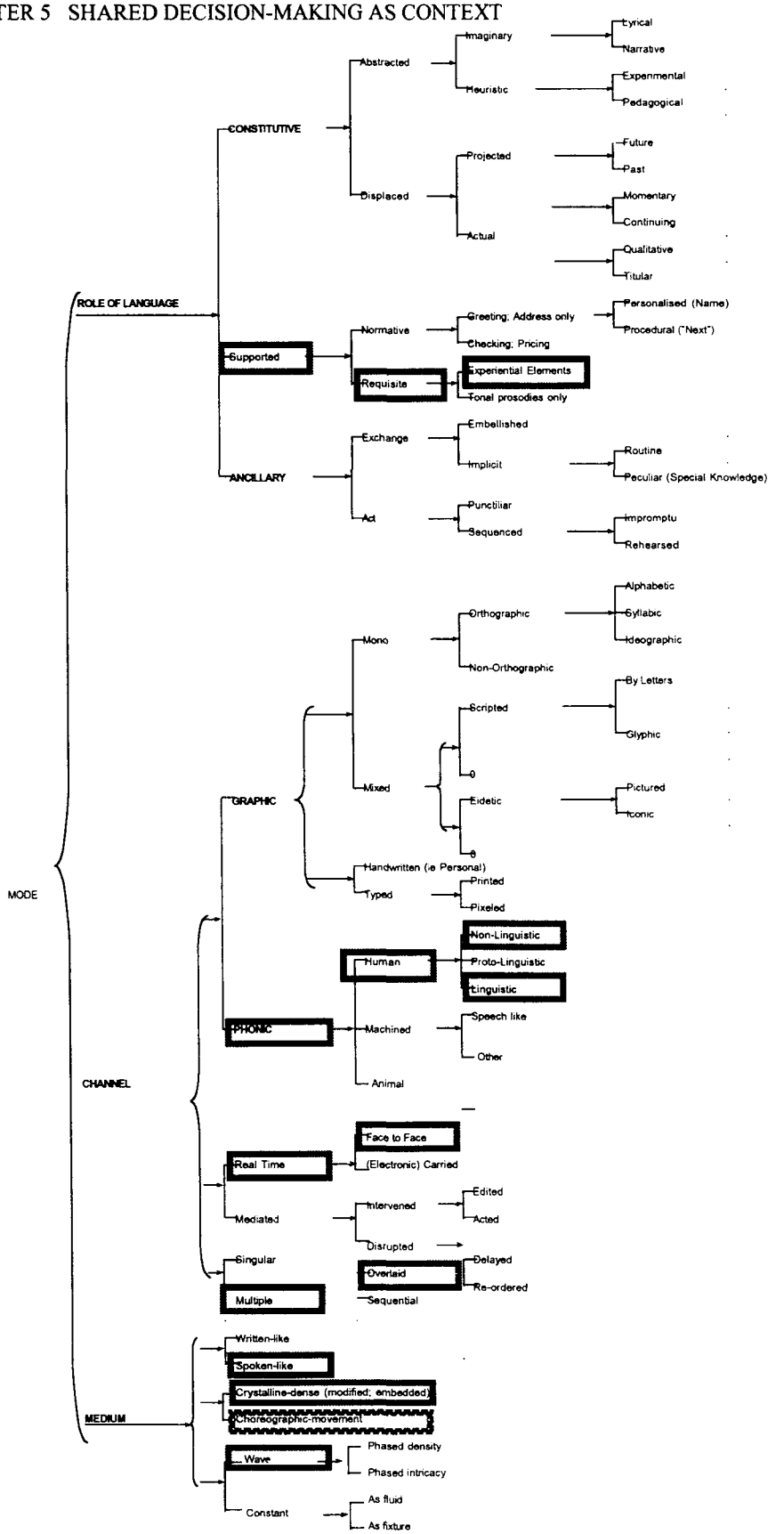

Figure 5.5 Mode settings for Consultation 29a (wart episode)

MODE

Taking this extract as a whole, the role of language can be seen to cover two distinct areas of meaning. Firstly, at 20_136, the patient's use of language can be seen as an instance in which the language is *constitutive* of the context: by virtue of the patient's speech at turn 136, a new social activity of the patient presenting with a problem of anal warts is initiated, within the surrounding discussion of other problems. This and subsequent turns up to 29_142 are also constitutive – the context of negotiating whether to perform a clinical examination of the warts is the main function of that stretch of speech, but during this part of the dialogue, the relation between verbal action (talking about the wart) and other, material activity (physically examining at the wart) becomes more tightly linked, with the verbal action foreshadowing the material action. Theoretically, such a context could be achieved without the material setting – for instance, if the patient was speaking to the doctor on the telephone, they could still set up a context of presenting anal warts as a problem to be investigated, although the foreshadowed examination would need to take place at some later time.

Secondly, from turn 189 and onwards, the role of the language changes. Here the language is inextricably linked to the physical actions being performed at the same time in shared space/place (including the patient's body), and would be classified as playing an *ancillary* or *supportive* role, rather than a constitutive role. For instance, the doctor's verbal move at turn 189, "this little thing here", would make no sense if the doctor and patient were not physically co-present. Turns 191 to 193 loosen their connection with the physical context somewhat, but "I'll just paint a little bit of stuff on it" is no doubt heard as an index of immediate action, not merely as the foreshadowing of action. Crucially, then, we must notice not just that the amount of discussion given to the wart's treatment is very minimal, but also that the role of language here is ancillary to action – treatment talk is merely part of the activity or process of treatment administration. A related issue under the heading of Mode is the degree of process-sharing. The minimal discussion of treatment here occurs by way of a process of enunciation. This process, and thus the whole of the decision about whether to treat and if so how, is conducted by the doctor alone, not as a shared process. I would argue that these two parameters of Mode are largely responsible for

the sense of unilateral, if not paternalistic, decision-making in this case. In particular, there is a lack of explicit deliberation and articulation of the decision, and especially a lack of exchange of turns between the patient and doctor about the treatment before it is undertaken.

CONTEXTUAL CONFIGURATION

As indicated in the discussion of Tenor above, the dimensions Field, Tenor and Mode are only partially independent: there is a loose inter-dependence or 'mutual prehension' between the parameters of context (Hasan 1999 after Firth). It is the configuration of these parameters as a whole which specifies the character of a context, and which links context to text in a relation of mutual realization (Hasan 1985a, 1999; cf. Thompson 1999).

In this episode of observation and decision-making about warts, there is a lack of explicit deliberation and articulation of the decision, which can be represented under Mode as *crystalline*[1] rather than *choreographic* medium. Co-occurring with a crystalline medium are *established, supported, context* in Field, and *shared technical symbolic capital* and *shared local history* in Tenor. The interaction of the these Field and Tenor parameters, which are otherwise associated with participatory decision-making, appears to mediate the low participation setting in Mode. Where the relations between clinical observation and treatment choice are familiar to both parties, and the level of codal sharing is high, it is highly likely that the setting *reciprocal agentive roles* is on a kind of "standby": it may be the case that the opportunity to check, probe, contradict (and even physically evade being treated) is available here, but the patient did not feel the need to take this opportunity up. On the other hand, the reciprocal agentive roles that I would argue are required for shared decision-making *may* in this case be set plainly to "off". There is really insufficient evidence, from the extract shown, to decide whether this episode should be

[1] The term 'crystalline' describes a mode of linguistic interaction where messages come as pre-packaged objects with other objects/messages embedded within them, which are not open for negotiation, whereas 'choreographic' describes a mode more open to interactive negotiation. (cf. Aronsson and Sätterlund-Larsson 1987). As with all the terms describing parameters of context in this model, it is the contrast between choices which is key.

considered shared decision-making or not. However, if we take into account the *co*-textual evidence of the surrounding consultation, and the subsequent consultations, we may feel in a better position to comment.

In expanding the focus out from the particular decision-making episode to the broader relationship and consultation style, it is important to note that this may entail re-conflating the notion of "patient centred medicine" with the notion of "shared decision-making", which Wensing et al. (2002) have argued should be kept conceptually apart. In section 5.4.2 below I describe the Field, Tenor and Mode settings for the primary context (the α context) in the wart episode described above (a secondary context or β context) is embedded. The primary context in this case, which largely comprises the consultation, is that of deciding how to modify the patient's current combination of antiviral drugs. I will argue that this makes the wart episode part of a *complex context*, and that the analysis of decisions in terms of their role in such complex contexts provides a crucial additional perspective on whether each decision can be said to be shared.

5.4.2 A shared decision about HAART?

The short episode described above which entailed examining, deciding to treat, and treating anal warts took place in the environment of a much longer, much more complex discussion about antiviral treatment in which the patient Neil and the doctor Trevor decided to change the combination of drugs. Although it is long, this transcribed consultation is presented here in its entirety, in order to:

- demonstrate how much consideration and discussion can go into such a decision-making episode (some decision-making discussions in the present corpus are even longer than this one);
- show how multiple contexts tend always to be in play, creating complex relationships between activities/ contexts;
- examine the extent to which this expansive decision-making episode and the abbreviated one examined above (about warts) can be said to be instances of the same decision-making style.

Consultation 29: Neil and Trevor, April 1997.

Turn		Text
1	P	Makes only, 'cause of when I took
2	D	Sorry, if we pretend it's not going. And it, you know after about ten minutes it will naturalize things. I shall read it in any case. Um, oh I know, ah . . I know, more or the less the overview was that we were wondering, or we were pretty pessimistic about the the=
3	P	=direction=
4	D	=actual regimen failing.
5	P	Ah
6	D	Weren't we?
7	P	Yes.
8	D	And we decided we'd leave it for, we'd give it a little space period. And then do the viral load again. And depending what the viral load was the second time round, be in a position to make a judgment. Well I don't know what it is, yet. So,
9	P	( )
10	D	I'm on tenterhooks as well.
11	P	Oh
12	D	I've got to look for it. I don't actually know the odds as I'm talking to you.
13	P	Oh, okay.
14	D	... It may be that we need to phone. 'Cause usually I do know. So it was done, but would rather do it next week, stress. So it was in fact taken on this date. Which is the eighteenth of March. Do you know, the um ((name of hospital)) or either them or, either them or us, as in ((name of clinic)), are being absolutely incredibly slow, I don't expect it to be slow, but it's the seventh of April, eighth of April and these were down on the eighteenth of March. This is the eleventh of February one. I'll have to phone them... go on to the next page, won't we. All right so that's ((moving chair)). Can you just do me a favour, can you look, you look at that number and I'll, I'll phone ((number)) and you tell me the rest of them.
15	P	((number))
16	D	((conversation on phone))
17	D	I'm just waiting for them to tell me what er when they were sent out. In the mean time you can look at your results. So the only things you need to look at. You're used to these now
18	P	Mm
19	D	So there's the CD four absolute number that line ... and then the viral load ... is
20	P	Yep
21	D	Now, ah what you need to look at, when you get two figures like that that are reasonably close, this the advantage of the log scale is that we know that anything within point five of each other is not significant. So four point seven three and four point six seven clearly that's within point five of each other.
22	P	Mm
23	D	So that's not significantly different. So we've just got to decide what that means to us in terms of ( ). It's not significantly different to the last measurement.
24	P	Yes, yes, I understand that.
25	D	But, we might decide it's very significant from this.
26	P	Mm-hm
27	D	From the previous one. Hasn't got any worse, let's put it that way.
28	P	No.
29	D	But it hasn't got any better,
30	P	Much better or it's not, not significantly better?
31	D	It has to go back to base line.
32	P	Yes, that's not actually any better at all really.
33	D	No. ((on phone)) . . .
34	D	Right okay. Neil I think it's fairly clearly, um but we just have to go back through the, through the drugs. Isn't it?
35	P	Mm
36	D	And so . . eh, in, what she got ((number)) there, now that was your number.
37	P	Yes, yes. ((laughs))
38	D	Yes, that's your number. That's your number. Okay. In ah - just to really confuse, you've got to be quick in this business - so, sometime like May or June you went on to zidovudine, 3TC and saquinavir.
39	P	Mm-hm.
40	D	Okay and that's what you've been on since. And you made that initial ah fantastic fantastical drop from one million to one thousand. Ah, talk about the light fantastic, that was pretty amazing. And maintained it until December, 'cause that, not significant, as you can see but it point five of the log. And then by February however, for one reason or another it didn't look like it was doing as much. . . So it got up point nine, so it was significant. And eh, and it's stayed that way. So it actually, it's not, we're not looking at a disaster here.
41	P	No, no. But
42	D	But we've we've
43	P	It seems to have levelled out a little bit. Well I thought it was only a little while afterwards. Yeah and as you say not significantly different to the
44	D	No

45 P To that count
46 D No. See where we looking at, let's take a look at the other. Three point ( ) Right naught point nine. Log in naught point nine and then ( ) is ah ( ) I mean it's significant.
47 P Yep
48 D Um, but you know, often when we see people failing on drug regiments they jump too long.
49 P Right, yes, yes.]
50 D So, it's not a disaster. But, clearly if you want us to together, to work towards best practice. The best practice is to get you down below er ten thousand.
51 P Yep.
52 D Then there is only one um, one management option, in the absence of inter current infection, which you haven't got.
53 P H-hmm
54 D There's only one management option, and that is to fiddle with the drug regime.
55 P Right, okay. I'm happy to do that.
56 D Okay.
57 P Especially with AZT
58 D Especially with AZT that we what?
59 P That we change
60 D How long have you been on AZT, that's the
61 P Well it's, since when
62 D Oh I see. It's not a great length of time.
63 P No. I am a little concerned about some of the things with compliance. Now I do take my medicine every day, but then sometimes things will say delay my evening one until quite late. And then of course, I mean say even ten thirty, eleven o'clock at night. And then in the morning I get up early, I take, take my medicine before I go for my walk at five o'clock in the morning. Now, I don't know with it, is that a good idea. Shall I try and space that out a bit more or should I um
64 D Is that when you do your power walk at five?
65 P Yes.
66 D The one I caught you doing along the main road by ((name of district))
67 P Yeah
68 D With the weights in the hand.
69 P No, no. No weights.
70 D I though I saw you with weights one day, no.
71 P It might have been some garbage that I picked up.
72 D ((laughs)) ( ) that's why I couldn't. I know it was you though. Um, well the point is that as long as you're not er missing doses, or missing more than one dose. I don't think it's going to make enough difference for you to destroy your life through it. Everyone's going to have some problem
73 P Sure. I mean mostly it's okay. Mostly I sort of am quite regular. But just occasionally I've been sort of 'delayed in one way or another and I've just worried oh is that delay sufficient to cause the sort of effect that we're having. In other words that it causes enough or allows enough resistance to occur to change that.
74 D Right. Well I think it's unlikely. I think it's unlikely that the um. So what are the choices?
75 P It's when people miss several times in a row or something like that.
76 D Yes
77 P They end up missing.
78 D Mm-mm.
79 P Okay.
80 D Ah, what are the choices? There was a group of people one stage who were putting it about you had to change all three. If you were going to change anything at all. I never really sort of fell for that, and I've never, and it seems to have fallen by the wayside that philosophy. Which is just as well 'cause we were getting rid of three options all at one go.
81 P Yes, that's right. I'm inclined to agree with that as well.
82 D Um, the options are, well let's take them one by one. The zidovudine should we change that? My inclin, my inclination is different to yours, I'm, I wouldn't be inclined actually to change that. But if we did want to change that, we'd change it from zidovudine to d4T. Have you heard about that one?
83 P You did mention it last time
84 D Did I? Zidovudine to um, it's called stavudine and
85 P What, I mean what would you
86 D That's one option. That's option, I'll just go through the options. Um 3TC is sort of a supporting drug, it's a supporting player really um, it's limited there. Supports certainly supports zidovudine and um in the sense that it prevents resistance. Doesn't prevent resistance but it helps it to prevent resistance. With Zidovudine resistance, er, isn't quite as er dramatic as with the protease inhibitors, but it does eventually happen and particularly people who have been on it for a long time. And you're not a person who's been on it for a long time. People have been on it seven or eight years.
87 P Yeah, yeah.

Consultation 29: Neil and Trevor, April 1997.

Turn...	Text
88 D	There's another, we like to have one class of compounds in the reserve- reverse transcriptase inhibit inhibitor group.
89 P	Mm
90 D	And there's another one called a virapine, that's also reverse transcriptase inhibited. That's also considered a bit of a supporting plan. And then we've got the protease inhibitors and so far there are three. There is a fourth about to come on the market. So we've got saquinavir, indinavir, ritonavir and this new one is going to be called nelfinavir. My inclination at the moment is to change you from saquinavir to indinavir.
91 P	Okay.
92 D	I mean, you know, if I just said change you from AZT to d4T, you'd have possibly been happier but you you wouldn't be happy if you knew, if you knew it was my second choice.
93 P	No. No, that's right, I mean yeah I think last time we only briefly touched on it and said "oh well there is this other thing as an alternate to AZT which is less toxic" and I'm a little concerned about the toxicity of that especially since I, I feel that I'm noticing some of the effects occurring.
94 D	Such as what?
95 P	Just that, that muscle there. I sort of looked at myself in the mirror you know, sort of looked a bit soft and wrinkly, where it didn't before, you know. Um, and that's
96 D	I didn't talk about that, you must've read about that one. Saggy butt it's called.
97 P	Saggy butt. Yes, yes or AIDS bum, or something ( )
98 D	AIDS bum could be anything.
99 P	That's it, it has been, you know mentioned possibly in the, the HIV sort of things that I've read. Um, but yeah it's not bad enough, to warrant changing from my suspicions on that alone. ( ) If that was your second choice ( ).
100 D	Subtle. It's subtle, both got so many options that it becomes a matter of subtlety and I have to say that um if you got a group of AIDS freaks in a room - doctors I'm talking about -
101 P	Yes ((laughs))
102 D	there'd by no means um . . by no means would there be a fabulous consensus. There would be a certain con, I mean there are certain things that you don't do.
103 P	Right
104 D	But when it comes to starting things you can do, people might go in different directions.
105 P	Sure.
106 D	I mean one of the things that people do, is to just add in indinavir, but I personally think if you, if you er think that saquinavir resistance is happening then you should switch it.
107 P	Right.
108 D	I, I can see people who, there is a trial for example going on where you have a number of reverse transcriptase inhibitors and then you put people on two protease inhibitors.
109 P	Right.
110 D	I can see some sort of rationale behind that. You know one providing resistance to the other. You can't see the rationale behind adding in another one, you might as well switch it. Um, did you meet Leila when you were here last? New staff member?
111 P	Um,
112 D	Nurse?
113 P	I, I'm not sure.
114 D	No, I mean
115 P	Yeah I can't remember.
116 D	I think I. I think I brought a doctor in to show,
117 P	Yeah, yes.
118 D	To show you to, but eh we've got a new um staff member called Leila who was the clinical nurse consultant at ((Hospital))
119 P	Oh right
120 D	You've heard of that one. Er, and on the AIDS unit and ah, we're using her quite a lot to chat with patients about how to fit in their regimes and, I think you should talk to her about how to rearrange your meals and stuff to take account with indinavir.
121 P	Yes well, this is the other thing too, I don't actually eat three meals a day
122 D	Oh well,
123 P	I only eat one and so
124 D	Well, that's fine
125 P	And so
126 D	That's fine for indinavir cause you're meant to have it on an empty stomach.
127 P	Right. Oh okay. ((laughs))
128 D	Um, can I just go over with you. We've more or less decided ( ). Er just wanted to check about your joint pain.
129 P	Um, I noticed a little bit of pain this morning in my knee and my shoulders, but, that's the first day for about like almost since I last was here, that I actually had any pain so. For a while it actually um you know went away almost entirely. I mean sort of, as opposed to waking up every morning with something hurting, um I then

went to sort of like oh maybe once a week I'd notice a little bit of pain
130D Yeah, okay.
131P But um
132D Well in that case, we've got other things on our plate at the moment so, shouldn't really sort of get wound up with that at the moment. Is that all right?
133P Yeah, yep that's fine.
134 ((tape off))
135D Guess we don't have any mess in there. ((talking while writing)) "Number one" - and I'm just summarising here - "number one, repeat viral load er, within naught point five of previous measurement... Which implies the support for hypotheses that this particular combo, Australian made combo, Combo is failing. Two, discussed various options. Um decided to change the saquinavir to indinavir. Number three I found here so, it's cp ( ), I found here um not disappeared but not prominent at this time."
136P However, I did notice that the anal wart that was treated, has returned.
137D That ( ) the wart ((laughs))
138P It's quite annoying actually, I found
139D Is it ?
140P Like yesterday I wiped my arse a bit hard and I actually bled. And I think I might have scraped it or
141D Do you want me to have a look at it, in other words?
142P I would, I would actually, like you, to check that out.
143D Okay
144P Just to have a look.
145D Anything else?
146P That's oh, yeah, that came up in the weekend, I don't know what it was, it didn't look like like a cold sore, like herpes outbreak.
147D You mean that ulcer on your lip.
148P Yeah
149D I'll have a look at it as well.
150P Yeah, safe
151D Okay.
152P How to treat ( ) Seems to be going away but it was quite swollen
153D ((Writing and talking)) "Four, anal warty, bleeding. Number five, ulcer on lower lip". We've got to get these redesigned, I mean these are pathetic. Look that's all the space I've got. I thought you were going to tell me in detail oh and then I turn it over and they've got diagnosis and what drugs and away we go.
154P Right
155D Right.
156P So maybe you were saying that muscle area and see whether you saw
157D Okay, oh did you weight yourself?
158P Yes, seventy four k.
159D All right. Thanks.
160P It's only one below, which is not surprising since I'm not eating much.
161D ((coughs)) I'll get some gloves
162P Yes
163D Then I'll look at you lip first. . . .
164 The pharmacist is out, I just want to have a quick word with her. Turn this to stop. ((turns off recorder))
165D The sore on your mouth, it's either one or two things, it's either herpes
166P Right, yeah.
167D Doesn't look like it
168P No, it looked different to herpes and I only get that on the inner side rather than the outside of the lips.
169D ((sneeze)) Excuse me. Herpes actually looks on the inner mouth looks sort of like I think the word we use is herpigenus or serpigenus. Like a, like a eh, like a snake.
170P Right okay.
171D Squiggly. That's more punched out isn't it?
172P Yeah.
173D It, it, it's, I think it's more what we call a abscess ulcer. Which unfortunately isn't very helpful because it doesn't have a specific etiology.
174P Right, it's one of those vague things that
175D Yeah, it is one of the things
176P Yeah, good. Could be caused by anything
177D Strange enough if you get them really badly.
178P Yep.
179D There's the, this will probably send the `willies' up you. But, the most effective treatment is Thalidomide.
180P Oh, that's all right, I'm not having any children. ((laughs)) Yes I really , Thalidomide is quite a useful drug except in pregnant women.
181D Thalidomide was a brilliant anti-inflammatory drug, there was a problem of course. It's used in leprosy. It's still used on leprosy and it turns out to be very good for mouth ulcers as well. Yeah, as you say the only bad thing about Thalidomide is its ( ) effect on pregnant women. Okay ( ). Oh you want me to have a look at that
182P Seems to be
183D Yeah it is a bit actually. Doesn't usually come on after this is quite so
184P This little weepyness.

Consultation 29: Neil and Trevor, April 1997.

Turn...	Text
185D	Oh that, oh I'm looking at the the uh bulk. What actually happen is this is where it goes.
186P	All right, so that's sort of yeah. Oh maybe I just thought my bum was tighter than that ((talking at examination table))
187D	Yeah and lie on your left side facing the wall that way, that's it. Didn't realise you were so vain.
188P	((laughs)) What do you think I go walking every morning for? The health fix almost set into ( ) reducing fat and so forth
189D	Oh, this little thing here?
190P	Yeah.
191 D	Is that what you're worried about?
192P	Oh, it's actually you know some of ( ) it's very irritating.
193D	Oh, I'll just paint a little bit of stuff on it.
194P	That's what you did last time it sort of, it sort of subsided. It just came back again. As I said, sort of quite irritating when I, wipe... So is there only the one, I just wasn't sure as well, not being able to see that area.
195D	Yeah. Oh sorry, correction two.
196P	Ah-huh
197D	There's a couple, there's three actually, sorry. ((laughs))
198P	Yes, I though there might be a couple more
199D	Rising.
200	P Rising in the ground
201 D	Okay, next time I might freeze them. Anyway coming back.
202	((moving back to desk))
203	...
204 P	This ulcer seems to be healing up at the moment. Um, should I, d'you reckon I do anything to it or just
205	D Er, no, nothing at the moment. So those, you need more of the anti-virals, right?
206 P	Yep.
207 D	Bactrim you've obviously got, cause you ( ) into that. And
208 P	But I think
209 D	You still need ( )pak
210 P	That was the thing I didn't seem to get enough, better make sure.
211 D	And
212 P	Once again, and have to come in half way through and have to come in specially to get bactrim.
213 D	Okay. And (erythromycin) right
214 P	Yeah. I didn't actually read the erythromycin pack very well and finally read it the other day and said "take on an empty stomach". I was going no wonder it makes me sick, take it with all of the others just before dinner, or just after dinner. So I realised that I had actually taken the directions. Suppose the empty stomach thing is to avoid nausea, oops, yeah, but I did so take a copy of this, much better actually. Now should I replace the saquinavir with the indinavir immediately and ignore the remaining tablets I've ( )
215D	( )
216P	Oh, half a ( )
217D	Oh, I'd give them back to us
218P	Yep okay
219D	Yeah.
220	P Didn't know whether that was, safe or what
221D	Makes more sense doesn't it. Made a decision.
222 P	Sure. Well sure, but yes I didn't know that I could actually bring unused medicine
223 D	I don't know, I'll have to ask the pharmacist.
224 P	Or, would they dispose of it, I suppose better than having things lying around.
225 D	You mean you're thinking of selling it on the black market?
226 P	Well, no but I mean in that, as in you know, sits around in your drawer in a jar, and somebody picks them up and goes oh these look pretty, what do they do. Scoffs a handful and gets really sick or something. I don't know what the saquinavir has side effect of that nature. I just thought that you've given the medicine you couldn't put it back into circulation.
227 D	I've got various forms to fill in...
228 P	I suppose I have to make my other appointment. For the next one, how far away? two months? or we going to
229 D	One month.
230 P	One month. Okay.
231 D	We'll do viral load again
232 P	Yeah, okay.
233 D	Fact. If it's successful really should have an effect within two to four weeks.
234 P	All right.
235 D	Noticeable effect.
236 P	So it's worth coming in for that... Yes, I was not sure, should it just show up within two months or whether, give it a chance. Now the indinavir doesn't have to be taken the same way as the saquinavir?
237 D	I can't think... Apply for it, fit into one of these... See if we can find you. What was it ((number)) wasn't it? Here we are, date ceased seventh four ninety seven. Apply for indinavir. I started somebody on all four yesterday, and I just spent about an hour filling in forms. ((code name))
238 P	((dob))

239 D What?
240 P ((dob))
241 D . . And ( ) a individual application . . . ( ) which just has to be copied on to this and your file on to file ( ). . . Date is
242 P Eighth
243 D I've asked you this about four times already. Just go and photocopy this. ((turns off tape)) Going out to lunch with the drug the drug firms. I very rarely have an hour to spare and secondly they bombard you. And so they've got me booked in to go for lunch at twelve and be back by one to see a patient with herpes. If I hang out for lunch till twelve the last thing I want to do to have to throw my food down and get back for a patient with herpes.
244 P Right.
245 D But that's what they're complaining at, at the desk this morning. Um, so while I'm looking, it's just giving me the opportunity however to count the number of people we've got on. I'm just getting to the right place.
246 P So do the drug companies do quite a bit of wooing the doctors
247 D Yes, but they don't get very far with us, because we just don't have . . the the usual thing is, I have to say, is that um they come in and they and you say right, you can have half an hour and then an hour later you're still trying to get them out of the place.
248 P Right, yes. Absolutely convinced they've got you as ah customer
249 D Yeah, that's right. Now let's see how many people are on. They'll ask me. Not that many as you can see. One, two, three, four, five, six, seven, eight. Where as saquinavir . . . They'll be hoping to pick up all this.
250 P I see
251 D One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, twenty-seven, twenty-eight, twenty-nine, thirty, thirty-one, thirty-two, thirty-three, thirty-four, thirty-five, thirty-six, thirty-seven, thirty-eight, thirty-nine, forty, forty-one.
252 P You've counted some of the people who are ceased.
253 D Oh, but that, yeah one or two here, ( ). Right, wunderbah, just got to get the drugs.
254 P Yeah.

The Field, Tenor and Mode descriptions of the HAART decision-making context instantiated in Consultation 29 are presented in Figures 5.6, 5.7 and 5.8. A comparison with the respective figures for the anal wart treatment context instantiated in the same consultation shows that the Field and Mode parameters for these two contexts are very different, but the Tenor of the two contexts is similar. I will discuss my interpretation of Field, Tenor and Mode in the long HAART decision-making episode, and then consider what the comparison between these two instances of decision-making suggests about how shared decision-making can be modelled.

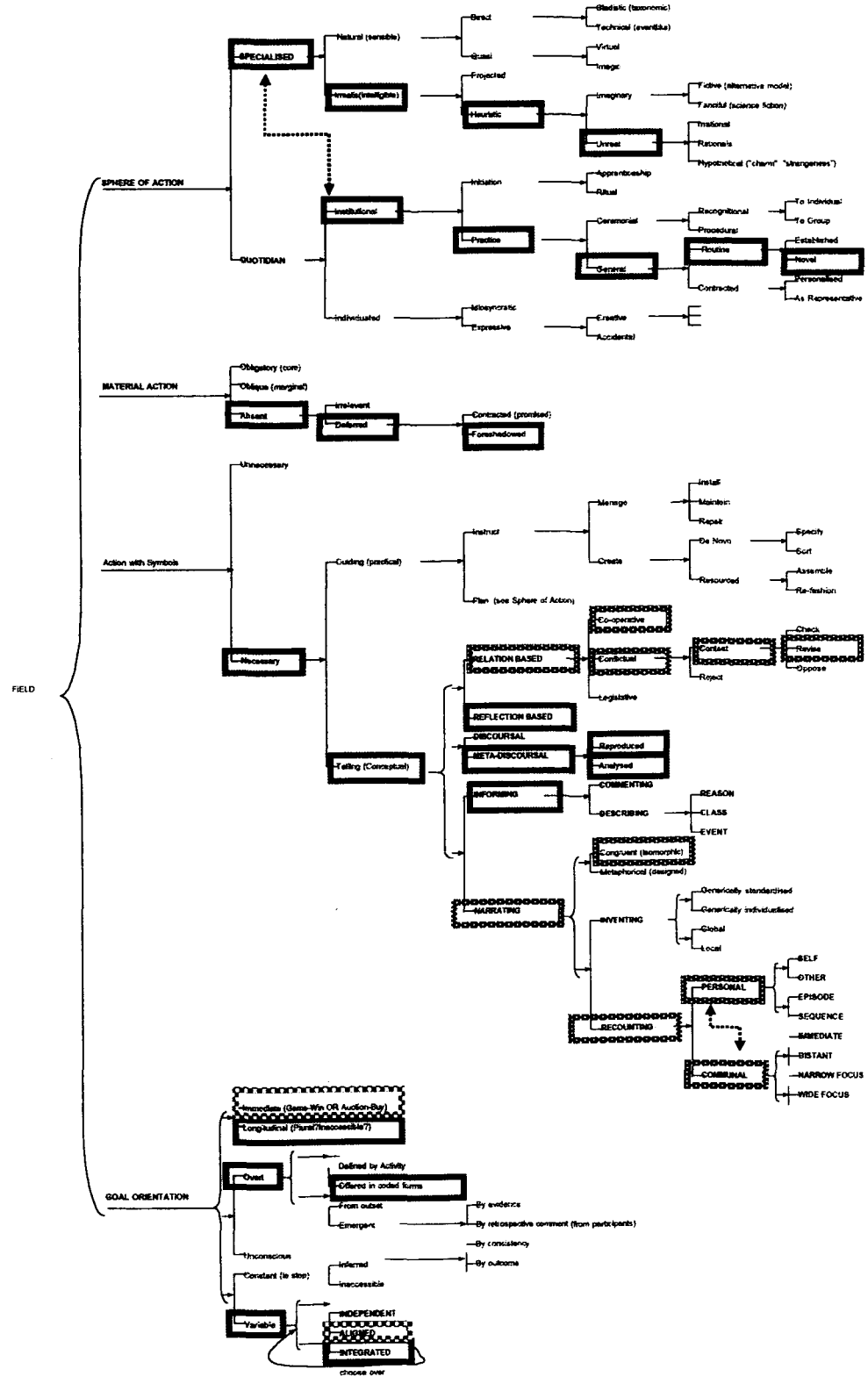

Figure 5.6 Network selections in Field, Consultation 29, Neil and Trevor: HAART decision

FIELD

In Trevor and Neil's discussion about changing the HAART combination, the SPHERE OF ACTION, although still a matter of routine institutional practice, involves a more *novel* activity than wart treatment. Changing HAART combinations is a novel practice for Neil and Trevor as a dyad – this appears to be the first occasion on which Neil and Trevor have discussed altering Neil's HAART combination – and, perhaps more crucially, as a sphere of institutional practice, the management and reviewing of combination therapy for people with HIV in community settings (including people involved in clinical trials) has been established for less than 12 months at the date of recording, and as Trevor points out there is no detailed consensus on the goals and methods of management within the institution. In addition, the sphere of action in discussing HAART treatment is more *specialised*; it involves *intelligible* rather than *sensible* phenomena, which are used for *heuristic* purposes rather than for guiding the unfolding of material action.

MATERIAL ACTION is germane to the context of deciding whether to change the antiviral combination, but it is absent from the decision-making context itself, and more specifically it is *deferred: foreshadowed.*

ACTION WITH SYMBOLS is the necessary and core mode of action in this Field. The discussion about changing treatments involves linguistic and other symbolic action that is *conceptual* rather than *guiding.* Within the area of conceptual symbolic action, the Field here can be further detailed covering a number of different combinations.

One distinctive combination of features in this instance (which appears to be typical of HIV treatment decision-making in this corpus) is symbolic activity that is *reflection-based,* as distinct from *relation-based.* Although it is probably uncommon for interactive contexts to contain only reflection-based symbolic activity or relation-based activity, the distinction is useful in analysis. Relation-based activities include chatting, swapping jokes, insulting, quarrelling, explicit shows of agreement or disagreement (Hasan 1999: 288). What makes them relation-*based* is that they foreground the social relation between speakers, and to some extent they background the semiotic relation between ideational or between textual elements. On the other

hand, reflection-based symbolic actions tend to downplay the enacting of social relations and "produce semiotic constructs such as explanations, generalisations, classifications and descriptions... thus they underlie all institutions and all knowledging" (Hasan 1999: 289). In this study then I will treat the parameters 'reflection-based' and 'relation-based' as two ends of a cline. Certainly in the present data, where symbolic action involves extensive reflection, it tends to retain its function as relation action as well (see immediately below). This consistent combination may be a particular characteristic of HIV and/or participative medical consulting styles, since in traditional consulting styles it is common for doctors not to display their diagnostic or therapeutic reasoning to the patient, but to undertake a kind of internal explanation to themselves, which can be construed as much less relation-based symbolic activity than that observed here.

Where symbolic action in Consultation 29 is reflection-based, it tends to be *informing* rather than narrating. For instance, in turns 63-72, the patient, Neil, raises a question about the effect of compliance and this is responded to by the doctor, Trevor:

29_63 P No. I am a little concerned about some of the things with compliance. Now I do take my medicine every day, but then sometimes things will say delay my evening one until quite late. And then of course, I mean say even ten thirty, eleven o'clock at night. And then in the morning I get up early, I take, take my medicine before I go for my walk at five o'clock in the morning. Now, I don't know with it, is that a good idea. Shall I try and space that out a bit more or should I um-
[turns omitted]
29_72 D Well the point is that as long as you're not er missing doses, or missing more than one dose. I don't think it's going to make enough difference for you to destroy your life through it. Everyone's going to have some problem.

This symbolic activity is reflection-based rather than relation based. Given that the topic is compliance and the initiating speaker is the patient, the symbolic action here could potentially be narrating. That is to say that we might expect the patient to be recounting,[1] as past experience, his problems with compliance. But in turns 63-72 (and notably throughout the corpus) the symbolic action is arguably *informing:*

[1] "recount" is used in a similar but broader sense than its use in SF narrative (e.g., Plum 1998/88; Martin and Plum 1997), i.e., an account which unfolds according to the temporal unfolding of events to which it refers, typically "x happened and then y happened and then z".

describing: classifying/reasoning. It is *not* so much narrating what happened as identifying the likely effects of habitual dosing behaviour, and hypothesising the likely effects of habitual treatment if dosing behaviour were to change.

Reflective symbolic action in the HAART decision in Consultation 29 also tends to be *discoursal* as distinct from *meta-discoursal,* in that it instantiates a particular discourse of HIV treatment, namely the importance of regular and timely dosing. Later in the discussion, the activity becomes *meta-discoursal* in the sense that it becomes no longer an instance of the discourse of how to manage HIV infection, but an analysis of that discourse.

100 D Subtle. It's subtle, both got so many options that it becomes a matter of subtlety and I have to say that um if you got a group of AIDS freaks in a room, doctors I'm talking about.
101 P Yes ((laughs))
102 D There's by no means um ... by no means would there be a fabulous consensus. There would be a certain con, I mean there are certain things that you don't do.
103 P Right
104 D But when it comes to starting things you can do, people might go in different directions.
105 P Sure
106 D I mean one of the things that people do, is to just add in indinavir, but I personally think if you, if you er think that saquinavir resistance is happening then you should switch it.

In turn 102 ff, the doctor is engaged in presenting treatment options/policies to the patient, but the symbolic activity here does not merely instantiate or reproduce a clinical discourse; rather, it *analyses* the discourse in which such options and policies are given value. This section is a discourse on the discourse of HIV medicine. To call this kind of symbolic action metadiscoursal is to point out how such discussion is different from much of what is known in the medical literature as discussing uncertainty. Such metadiscoursal activity is a key feature of HIV treatment discussions, and of HIV health care interactions more generally, but it is also present in other highly politicised fields of healthcare including breast cancer decision-making consultations (Ainsworth-Vaughn 1998; cf. Butt and Moore 2002). It does however seem to be to be the case that doctors in the present study often make use of reflective symbolic action that is not relation-based, while patients are more often obliged to package their own reflective action as relation-based. In the exchange about compliance given above, the patient is seeking expert opinion and information,

a relation embedded in the activity of "consultation", and the doctor provides an opinion, albeit in a rather minimal way.

Somewhat distinct from the above type of symbolic action, we also find in Consultation 29, and in HIV medicine more generally, *relation-based* symbolic action which is *narrating* rather than *informing*. In Consultation 29, narrating is not a prominent type of symbolic activity, but arguably the HAART decision-making episode is embedded within an ongoing narrative of the joint management of the patient's HIV infection, and this can be seen in the fact that in those parts of the consultation which are narrative the "past experience" that is recounted tends to be the joint experience of the clinical goals and strategies, or else it is the social and personal recounting of experience which elsewhere is often considered as either (i) outside the medical frame (e.g., Coupland et al. 1994) or (ii) as a parallel context/text which could have occurred anyway and only coincidentally occurred in the same interaction as the clinical consultation (Hasan 1999). I would argue however that in many cases this would be failing to appreciate the specific Field of the main context being played out through interaction, and its links with Tenor and Mode.

The final dimension of Field to describe is GOAL ORIENTATION. In this decision about HAART, the goal orientation is *plural* and *longitudinal*. The decision to change the current regimen is related to a very long-term goal of maximising the patient's quality and quantity of life, and this is related to a more immediate goal of controlling the viral replication. These goals are largely *overt* in this context, and *offered in coded forms*. The goal of controlling viral replication is offered largely through the exchange of information about the patient's viral load and T-cell results (turns 14-33). The codes through which this goal is negotiated include the metric of viral and T-cell measurement, along with the related technical discourse of statistical significance. The point here is that although the goals in this Field of HAART decision-making are primarily overt in the sense that the goal orientation of the participants is available to the observer, this does not mean that they are explicitly declared as goals. Often coded forms of goals emerge as the situation unfolds, and are made apparent only by retrospective comment, or by virtue of evidence such as

whether further action is "required" (cf. Adelswärd and Sachs 1998). This is the case in Consultation 29 – the discussion of how to *identify* a significant difference in viral load can be taken as evidence that the goal is to *make* a significant difference (reduction) in viral load, through the administration of the most effective combination. The most explicit this gets is in the doctor's statement at turn 50:

50 D So, it's not a disaster. But, clearly if you want us to together, to work towards best practice, the best practice is to get you down below er ten thousand.

As the consultation continues it becomes apparent that the patient agrees with, or at least accepts, this goal:

51 P Yep.
52 D Then there is only one um, one management option, in the absence of inter current infection, which you haven't got.
53 P H-hmm
54 D There's only one management option, and that is to fiddle with the drug regime.
55 P Right, okay. I'm happy to do that.

The goals of this consultation appear to include a projected very long-term goal to maximise the patient's health (not coded), a mid-term (and evaluable) goal to get the patient's viral load down to under 10,000 (turn 50), a more immediate (and less evaluable) goal to ascertain the best management strategy (implied in turns 52 and 54). Then there are more immediate goals, such as to identify options (turn 82 ff), along with many others which are not necessarily accessible to the analyst and which may or may not influence whether this decision about antiviral treatment is shared by the doctor and the patient. For example, a possible, less overt goal in this context is to persuade the patient to stay on AZT. This example illustrates the fact that goals in complex contexts can vary by participant. It is important not just to specify the various goals but also to understand their relation to each other.

For modelling shared decision-making it is especially important to know whether the goals remain *independent* of each other, or are brought into *alignment* or *integration*, as appears to be the case in Consultation 29. In characterising or defining shared decision-making, the issue is not so much whether doctors' goals and

patients' goals are the same; it is more crucial that the activity be construed and carried out as one with potentially differing goals, so that integration of such goals is part of the design of the activity. In the antiviral treatment decisions analysed here, where the nature of the activity is construed as one that requires participants' goals to be integrated, this tends to co-occur with a particular Tenor, as discussed in the next section[1].

TENOR

The Tenor of the HAART decision in Consultation 29 is very similar to the Tenor construed in the decision about wart treatment. The analysis differs in only a few ways – ways which suggest that the Tenor of the HAART decision is one that is highly likely to accommodate shared decision-making.

In terms of SOCIAL HIERARCHY, there is something of a non-hierarchic quality to the relationship. Some of the discussion is redolent of peer-level working relationships and recreational relationships, including playful banter about 5 a.m. power walks, "saggy butt" side effects, thalidomide, and pregnant gay men. However, this non-hierarchic strand does not dominate; in my view, the overall Tenor in of the HAART decision-making episode is of a *hierarchical* relationship, but one in which the roles are *mutable*, changing with the phase. For example, at turn 63 and at turn 92, the patient directs the way in which the issues are elaborated, and sets out a kind of challenge to the doctor's recommendation and rationale.

[1] In other examples, including the wart decision above, the actvity is construed as not likely to have diverging goals, but this is still within the bounds of shared decision-making, since other parameters of context come into play, as described in detail above.

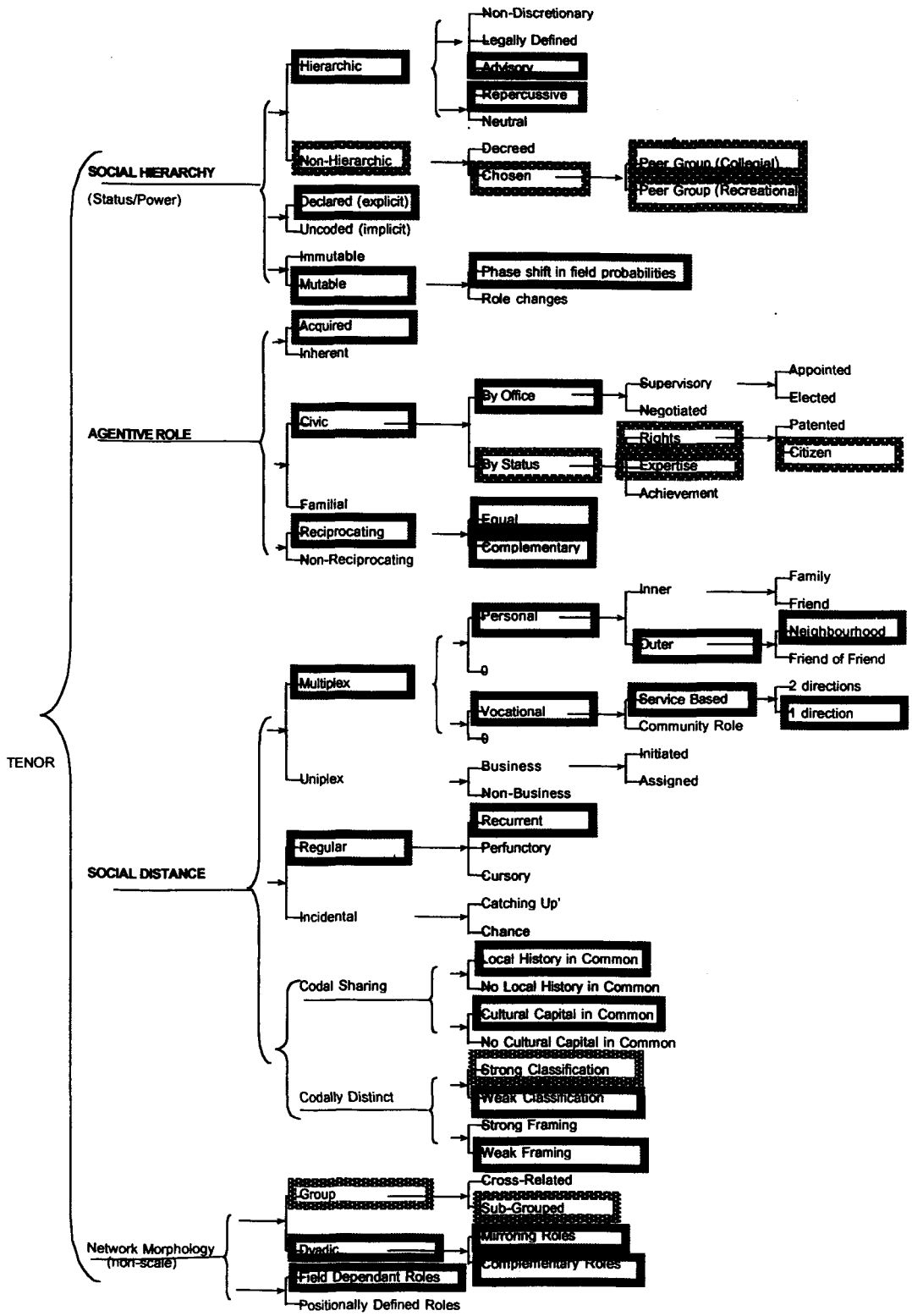

Figure 5.7 Network selections in Tenor, Consultation 29, Neil and Trevor: HAART

The tendency towards doctor-led hierarchical roles combines with *advisory* and *repercussive* parameters. The doctor is positioned in this discussion – both by himself and by the patient – as the holder of particular expertise and knowledge, generating recommendations about treatment which the patient should take as advice rather than merely as the preferences of a peer. Thus the hierarchy is *declared.* That is to say that although the patient is free to express his opinion and interrogate and attempt to influence the doctor, he is not free to ignore the doctor's point of view, or to merely acknowledge the doctor's point of view and politely differ. Neil and Trevor appear to view ignoring the doctor's advice as tantamount to wasted expertise and lost wellbeing. Any social/institutional repercussions are hypothetical here, as the patient's potential disagreement is anticipated (turn 58) and pre-emptively managed by the doctor in this case (e.g., Turn 92; 128).

The AGENTIVE ROLES in the HAART decision remain those of patient and doctor: their relations are *civic*, deriving from and construing both *office* and *status.* The agentive roles are *reciprocating,* in that the action is bi-directional, with the doctor and patient acting on each other. Largely, this action takes *complementary* forms, with the doctor taking the more active agentive role and the patient taking the more passive one, such as when the doctor provides information and advice, and the patient is the recipient of such information and advice (see Turns 21 ff; 63 ff, 83ff) or where the doctor acts materially on the physical body of the patient, such as in taking blood (or examining and treating warts). Even where material action is absent from the activity at hand, there is a potential relation of material agent/material goal that is never very far from the surface in the agentive roles of doctors and patients, and it re-appears as instructions from the doctor to the patient to physically return to the doctor's clinic for follow-up blood tests (turn 228 ff), to physically return unused drugs to the clinic (turn 217 ff), and even to read a number to the doctor while he dials the phone (turn 14). As well as such conventional complementary roles[1], in this HAART decision the patient is also the source of knowledge and the doctor is the

[1] Although I am referring to agentive roles in which doctors are active and patients are passive as "conventional", it must be acknowledged that such convention is a rather recent historical phenomenon. Until the 18th-19th Century, the doctor-patient relationship was primary in Western medicine, and doctors and patients participated in consensual dialogue. (Jewson 1977, Rosenberg 1979).

recipient of it. For instance, when the doctor makes a declaration that there is only one management option (turn 54), the patient (turn 55) explicitly declares his consent to such a plan, and begins to elaborate and qualify the plan.

54 D There's only one management option, and that is to fiddle with the drug regime.
55 P Right, okay. I'm happy to do that.
56 D Okay.
57 P Especially with AZT

Again at turn 81, the patient explicitly declares his agreement with one line of clinical reasoning rather than another.

80 D Ah, what are the choices? There was a group of people one stage who were pretty ( ) about you had to change all three. If you were going to change anything at all. I never really sort of fell for that, and I've never, and it seems to have fallen by the wayside that philosophy. Which is just as well 'cause we were getting rid of three options all at one go.
81 P Yes, that's right. I'm inclined to agree with that as well.

Even though the patient does not here oppose the doctor's reasoning, he is construing himself as potentially in a position to oppose, to have a different view of the clinical reasoning, or to refrain from agreeing to the only management option possible. These declarations thus position the patient as a legitimately the holder of a clinical perspective, and the context as one in which there relatively are equal agentive roles.

These equal roles are partly construed as a function of the *expertise* of the patient, but are also construed as something that the patient has by way of *rights*, that do not depend on his having any special *expertise*. Following Maton (2000), we can characterise these as different modes of legitimation. The "knowledge mode" emphasises relations between knowledge and its proclaimed object of study — the epistemic relation — while the "knower mode" emphasises relations between knowledge and its author — the social relation. This distinction is an important one, because favouring an expertise-based distribution of agentive roles implies employing a knowledge mode of legitimation, and probably leads to more interactive shared decision-making. Favouring equal roles based on *rights* alone, including expecting patients to make an "informed choice" with the expertise of the patient and the doctor being valued equally as epistemic claim may result in what is fairly criticised as "abandoning the patient".

In terms of SOCIAL DISTANCE, this decision-making episode construes a *recurrent* relationship. Although it is predominantly a professional or *vocational* relationship, there is evidence of an additional dimension which makes this relationship *multiplex*: the doctor and patient draw their membership of the same local *community* into their clinical relationship. This is marginal in this consultation, but significant nonetheless. It is relevant in the social relationship of the doctor and patient because the doctor makes it relevant when he acknowledges his recognition of Neil on his early morning walk (turn 64). I would argue that the choice to acknowledge rather than ignore the extra-professional connection is a sign of *weak classification* between the institutional and the personal domain, and that this is a feature of HIV medicine.

The dimension of *strong/weak classification*, and its related notion of *strong/weak framing*, are two of the most central contextual dimensions which allow or preclude shared medical decision-making. Where strong boundaries and spaces are maintained between discourses (strong classification), there may also be strong framing of how such discourses should be spoken, and of who may have access to these discourses and ways of speaking. In Mishler's work, for example, the emphasis on adjusting the power balance in medicine to privilege the voice of the lifeworld rather than the voice of medicine is simultaneously a strongly classified and strongly framed discourse: the lifeworld retains a different cosmology from the world of medicine. But in HIV discourse, it is apparent that the cosmology of the lifeworld of the patient with HIV overlaps considerably with that of the medical discourse of HIV; and the lifeworld of the doctor and the patient are continually brought into the same ontological frame and interactional frame as well. In HIV medicine, as demonstrated here and elsewhere in this thesis, the world of the clinic and the world outside the clinic are much less strongly classified domains of knowledge than the empirical literature on doctor-patient communication would suggest is normally the case, and access to these interdependent and jointly evolving sets of knowledge is much less strongly framed than is usually reported to be typical of medical consultations.

It may turn out that it is only possible to have shared decision-making when there is weak framing and possibly also weak classification; certainly it would be productive to conduct research focussing on a Bernsteinian analysis of medical discourse, which does not appear to have been undertaken to date[1]. It would be interesting to re-consider, for instance, Waitzkin's (1991) critique of American medicine as "excluding social context from critical attention", in terms of exhibiting strong classification. The models of discourse and practice that Waitzkin (1991: 269 ff) offers as an alternative, such as descriptions of cases and their treatment from postrevolutionary Cuba, in which doctors visit patients' homes and work in co-ordination with voluntary and professional groups across what we know as "sectors" (from education, to sanitation, and back to nutrition, mental health, and pharmacological remedies), certainly stand out as examples of weak classification.

Although the consultations in my study all took place in the doctor's surgery/room/clinic, and not at the patient's home, they do not appear to marginalise social context or exclude a critical appraisal of it in the way that many authors claim is typical of Western medicine in general (Waitzkin 1991, Mishler 1984, West 1984). In HIV medicine – and I would suggest this extends to shared decision-making generally – social contexts outside the clinic are often brought into the deliberations about what kinds of decision would be appropriate and sustainable. Each instance of recontextualising the social has a 'local significance' to that particular consultation, and in addition it has a more general and accumulating significance to the doctor-patient relationship, potentially paving the way for future decisions and increasing the shared cultural capital available to be drawn on in later decisions. See, however, Race et al's (2001) critique of what they describe as a style of communication in which the doctor includes and attends to the patient's lifeworld but in a way which constructs the lifeworld as the impediment to adherence or to treatment success, and in which the doctor explores the lifeworld only in order to correct it.

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[1] Bernstein's theories have been applied extensively in educational linguistics, however. See Christie (1999).

Another way in which HIV medical interactions incorporate social contexts and normally excluded from the dyadic clinical consultation can be seen if we consider the social NETWORK MORPHOLOGY involved in the HAART decision episode in Consultation 29. Ostensibly the relation in this discussion is a dyadic one, but there is evidence of this dyad functioning as part of a broader social network. The most obvious example is the reference in turn 110 to the new nurse, Leila. At this clinic patients (may) have a relationship with a clinical team, although their primary relationship is clearly with the GP. The nurse is positioned, for instance, as having quite a different agentive role than the doctor, and covering a partially overlapping field. The patient is advised to see her to get advice on implementing the treatment decision he is making with the doctor, but she has no agentive role with respect to deciding about treatment.

A less obvious textual link to an extended network within which the doctor-patient relationship is positioned comes in turn 93 ff. The patient informs the doctor that he is having side effects. The knowledge of a link between AZT and "saggy butt" is recognised as legitimate by the doctor, but it is not knowledge that the patient has received from the doctor[1]. This exchange does not ultimately influence the decision about how to modify the treatment regimen, since the patient discounts this side effect as a criterion for decision-making: it is not worrying him enough at this point to disrupt his acceptance of the doctor's opinion as the best indicator. What is crucial to the context of shared decision-making here is the unproblematized recognition of the patient's independent access to discourses and information about HIV treatment. That this is an important feature of HIV medicine is confirmed by observing the number and nature of peer support materials, such as web sites, which construct a virtual social network of HIV+ people as consumers and providers of health care and health information, and of social support more generally. Informal

[1] In an Australian study of HIV treatment access and practices, 26% of respondents who experienced side effects of HAART had not been informed about at least one of the effects they experienced. 70% of people who experienced HAART side effects subsequently discussed these with their doctor (Prestage et al. 2001). Many side effects only emerged as widespread problems only in late phase clinical trials; therefore, it was difficult for doctors to warn patients in advance.

observation of the many doctors and patients who participate in the same geographical and non-virtual social network further confirms this.

MODE

The HAART decision in Consultation 29, given its Field and Tenor as described above, can be seen as a complex context in which the ROLE OF LANGUAGE is constitutive, as shown in Figure 5.8 below. It is largely through language that the patient and doctor enact and identify the Field and Tenor parameters discussed above, and it is almost entirely through language that they achieve an understanding of being involved in a decision-making exercise as distinct from some other clinical activity, and that they undertake that process, terminate it, know whether and when they are finished, ascertain whether they agree, and so on.

The CHANNEL of the decision about HAART is principally phonic. The doctor does write down his summation of clinical markers and decision outcomes, but the contact between the patient and the doctor does not appear to be via the graphic channel (except in the case of the report of viral load and T-cell counts, which are not specified in the spoken transcript – they are written down and referred to anaphorically). Thus the opportunity for real-time process-sharing is high. The opportunity for process sharing is taken up and yields a relatively dialogic consultation. Neither the patient nor the doctor consistently operates in monologic mode, and the decision-making unfolds with opportunities for each party to affect its direction along the way. Thus the MEDIUM of interaction is principally *spoken-like* and *choreographic*.

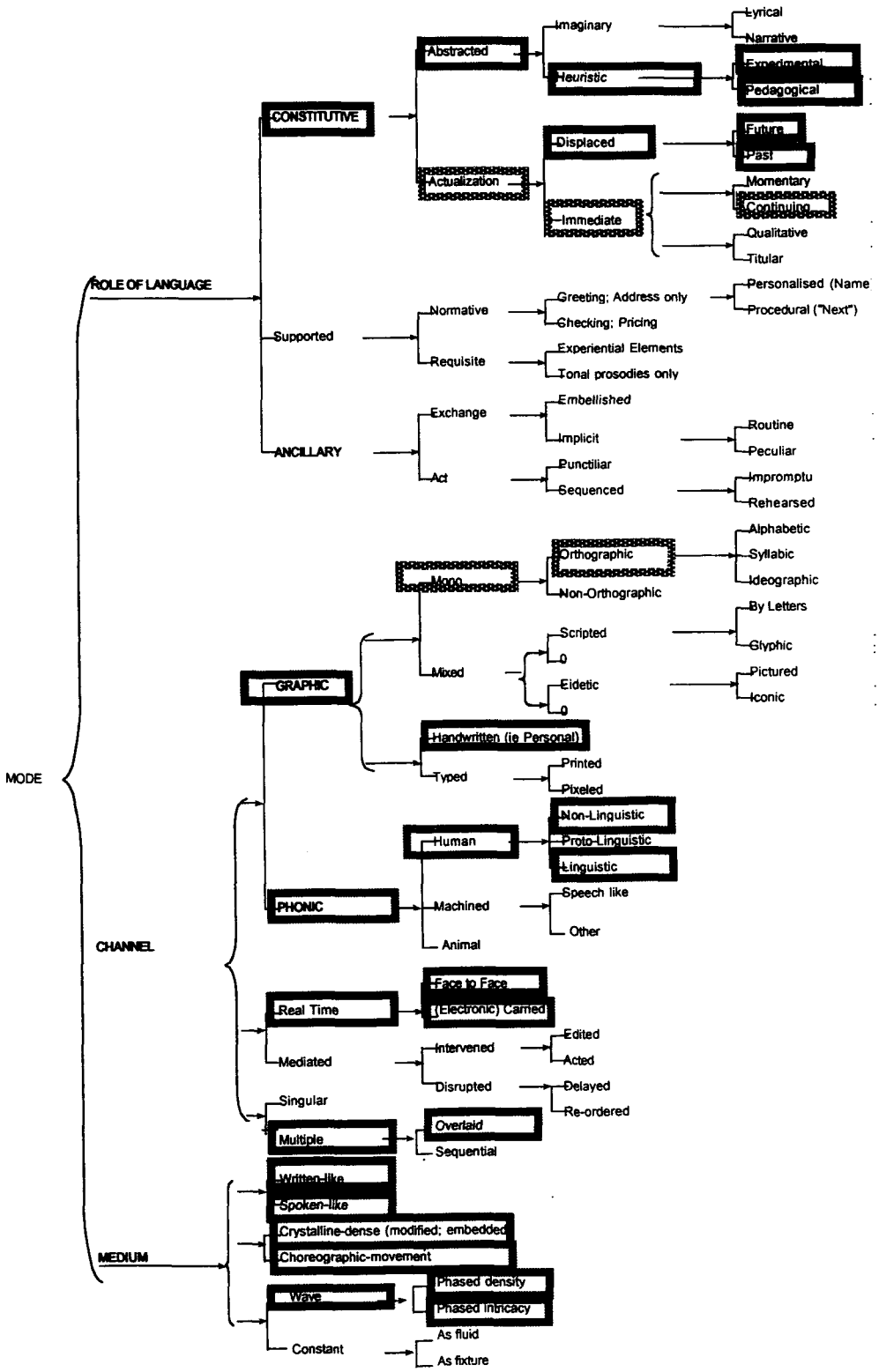

Figure 5.8 Mode settings, Consultation 29, Trevor and Neil, HAART decision

There is however an important effect of use of a graphic channel on the medium here, making sections of the decision more *crystalline* (coming all of a piece). In these sections, components of the decision are embedded in a way that prevents their separate availability for evaluation or comment. This dual writing-speaking mode occurs at critical points in the decision-making process, and arguably has an effect on the distribution of agentive roles. The written-like MEDIUM which is realized through the phonic CHANNEL imbues these sections with the sense of completing or recapitulating moves which are still within the deliberative span, thus raising the stakes of disagreement. Sometimes this summative function is declared, as in the section of Consultation 29 repeated below.

128	D	Um, can I just go over with you. We've more or less decided ( ). Er just wanted to check about your joint pain.
129	P	Um, I noticed a little bit of pain this morning in my knee and my shoulders, but, that's the first day for about like almost since I last was here, that I actually had any pain so. For a while it actually um you know went away almost entirely. I mean sort of, as opposed to waking up every morning with something hurting, um I then went to sort of like oh maybe once a week I'd notice a little bit of pain
130	D	Yeah, okay.
131	P	But um
132	D	Well in that case, we've got other things on our plate at the moment so, shouldn't really sort of get wound up with that at the moment. Is that all right?
133	P	Yeah, yep that's fine.
134		((tape off))
135	D	((talking while writing)) "Number one" - and I'm just summarising here - "number one, repeat viral load er, within naught point five of previous measurement... Which implies the support for hypotheses that this particular combo, Australian made combo, Combo is failing. Two, discussed various options. Um decided to change the saquinavir to indinavir. Number three I found here so, it's cp ( ), I found here um not disappeared but not prominent at this time."
136	P	"However, I did notice that the anal wart that was treated, has returned."
137	D	That ( ) the wart ((laughs))

In this extract, the switch from spoken-only to spoken-written medium accompanies and facilitates a switch from deliberation to enunciation of the planned treatment. In more general terms, this is a movement from a *constitutive* role for language to a more *ancillary* one; and a shift from *conceptual symbolic action* dominating the Field to more materially oriented or *practical* symbolic action, closing the gap from "how shall we interpret these results" to "take these twice a day".

Up to the point shown in the above extract, the decision-making process has involved the following symbolic activities:

a) agreeing that modifying the treatment regimen is necessary;
b) suggesting and dispreferring the option of swapping AZT for another drug;
c) identifying saquinavir as the likely problem;
d) identifying indinavir as a potential replacement for saquinavir; and
e) establishing that the patient's pattern of meals makes indinavir a suitable choice.

The state of play at the beginning of this extract (turn 128) is that the dyad has "more or less decided" how to modify the treatment regimen. By turn 135, in the written-spoken section, the decision is presented (again by the doctor) as finalised, no longer incomplete or partial. As far as the transcript shows, there is no further explicit deliberation about how to modify the HAART regimen[1].

By implication, the rhetorical pathway from "more or less decided" to "decided" in this case involves only the ruling out of a potential barrier, and perhaps the passing of time with no objection or counter-suggestion by the patient. This method of development of decisions is common in the present corpus, revealing ways in which decision-making is often dispersed and incremental (cf. Boden 1994, Atkinson 1995, 1999), and showing how it is often the supposedly retrospective comment about a decision that constitutes the decision itself (or at least tips it from the irrealis into the realis).

This discussion of how shifts in contextual parameters and their configurations are associated with the incremental unfolding of decisions begins to suggest that a more explicitly dynamic approach to describing the context of decision-making in HIV medicine is required. This will be the focus of section 5.5 below, which will draw on the contextual parameters that have been illustrated above to show how phase shifts are indicated by changes in the configuration of network selections for Field, Tenor and Mode (cf. Hasan 1985a and others). I will argue that characterising medical decision-making as shared or otherwise depends on an understanding of how contextual parameters may be set consistently throughout a whole consultation,

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[1] Unfortunately, the tape was turned off for a short period between the "more or less decided" and "decided" marks; however, it is unlikely that further deliberation took place during this time, since the policy of the doctor taping the consultation was to shut the tape off only when he left the room, and to switch it on when he came back.

and of how they may activate and de-activate, group and re-group, reflecting the subtle moment-to-moment transitions in context that can emerge (cf. Goodwin and Goodwin 1992 and others). Before turning to that discussion, it remains to summarize the possibilities for describing shared and other styles of decision-making in terms of dimensions of context, and to report briefly on the distribution of these styles of decision-making across the present corpus.

5.4.3 Comparing decisions and contexts

Figure 5.9 juxtaposes the networks presented earlier. The networks are meant to be seen here as schematic representations of the way in which two different decision-making episodes take up different meaning spaces, according to a diagrammatic representation of that space. The shapes of the paths indicated in the diagrams show that the Tenor is quite similar between the two episodes, but that the Field and Mode vary.

Field, Tenor and Mode are seen as permeable and interdependent dimensions of context. It is usually not possible to change one dimension without having at least a subtle effect on the others. But in some cases the attendant effects in one dimension will of course run counter to the desired effects in the other two. The particular conflict we see in the wart example is between *goal orientation: overt* and *social distance: cultural capital and local history in common*. If doctors and patients were required to expand each decision into the most complete instantiation of shared decision-making as it is prescribed by models such as Charles et al. (1999a) and Elwyn et al. (2001), this would change the *goal orientation* into one in which specific goals were declared and made available for negotiation to both doctor and patient. But it would simultaneously change the social distance, portraying and enacting a context with less recurrent contact, with less shared history and less shared symbolic capital. In the context of deciding about HAART, a setting in goal orientation that seeks to explicate and align goals does not have this inappropriate effect on Tenor, since the Field is novel enough to warrant a departure from the assumption of single or invariable goals.

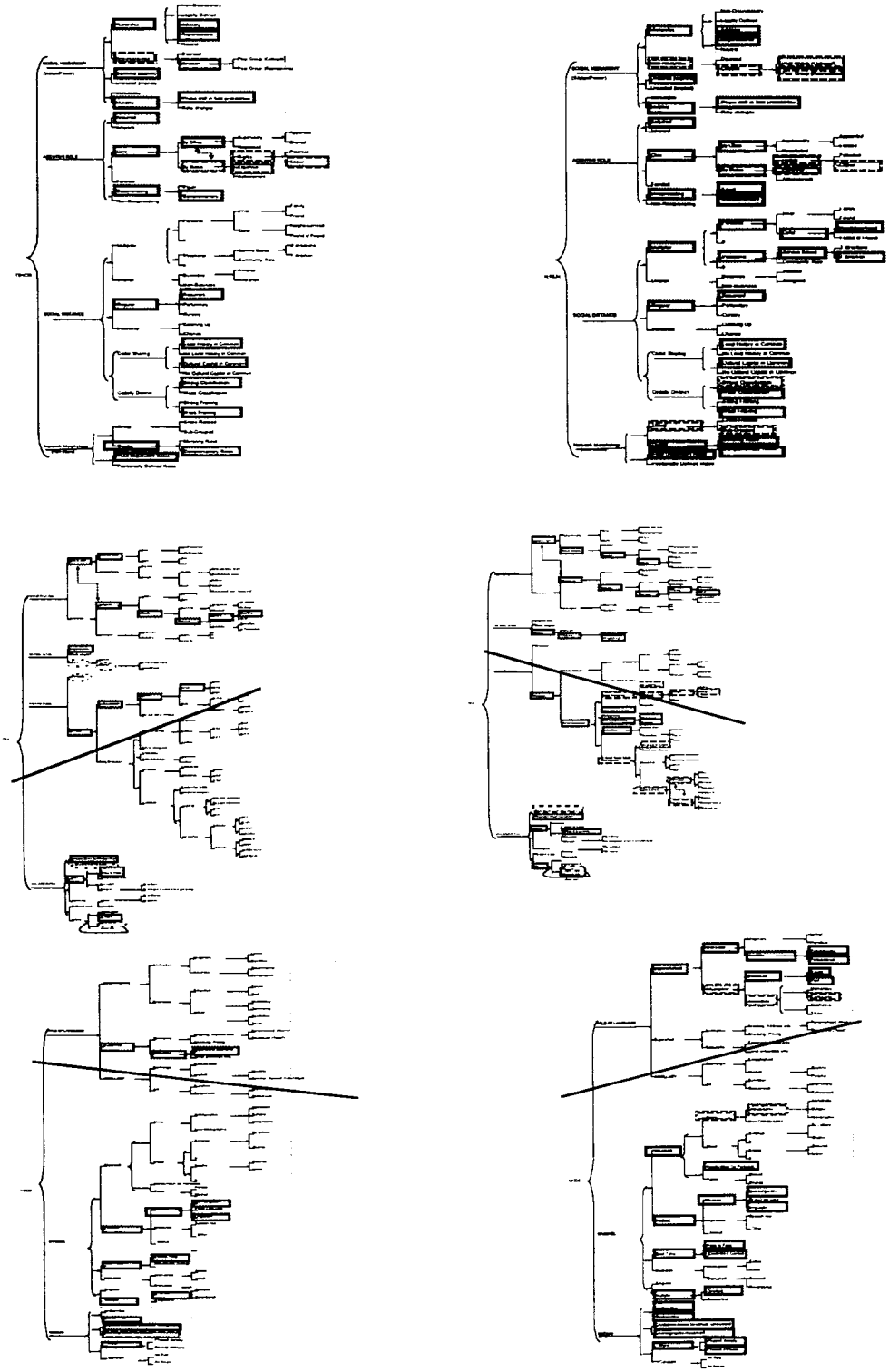

Figure 5.9 Comparing wart (L) and HAART decisions (R), for Tenor, Field and Mode

Although this is a complicated way of viewing the phenomenon of shared decision-making in HIV medicine, it does help to explain why it is misleading to portray shared decision-making as a halfway house between paternalistic and informed choice. On several dimensions, shared decision-making is the most extreme of the three positions. For instance, shared decision-making involves the highest level of process-sharing (Mode) and a higher level of codal sharing (Tenor), and tends to include more metadiscoursal symbolic action and variable goal orientation (Field), compared with either "paternalistic" or "informed choice" styles of decision-making. This analysis also helps to explain why injunctions for doctors to do the negotiation of preferred decision-making style as a distinct "step" is not easy for doctors to comply with, and why shared decision-making is difficult to practice and difficult to identify in practice (cf. Elwyn, Edwards and Kinnersley 1999).

It is likely that shared decision-making is under-utilised *not only* because it threatens the power balance between doctors and patients in institutional medicine (Elwyn, Edwards and Kinnersley 1999) but also because it may call for "impossible" combinations of contextual parameters. It is not, of course, that these combinations are necessarily or logically impossible, but rather that our culture is attempting to renovate existing social processes with the verbal and interactional materials used in the original buildings. As Erickson points out (2001), discursively mediated social change always relies heavily on a process he describes as bricolage[1] (after Levi-Strauss 1966), whereby interactants make use of whatever symbolic materials are at hand, including those "designed" for quite different purposes in the pursuit of some novel context or discourse. There may be "wiggle room", as Erickson calls it, for interactants to move out of hegemonic genres. But at this point in the history of the development of shared decision-making in medicine it is largely up to individual interactants and dyads to creatively find ways of talking and interacting that move them into that the wiggle zone. Their task is nothing short of expanding the meaning

[1] After the French term "bricoleur", referring to a workman (sic) who uses whatever is at hand, including discarded objects intended for some other purpose, to build or repair buildings, furniture etc. The bricoleur constrasts with the craftsman who insists on the right materials, which are "raw ingredients" rather than pre-fabricated or recycled.

potential of their shared language. For those who participate in medical consultations in a second or foreign language, this task may be particularly large.

This is a similar argument to the one made by Little, Jordens et al. (2002), that in policy-making contexts consumer advocates cannot rely on their individual personal experience (e.g., as a cancer survivor) as any claim to authority, or as a discursive resource for participating in the policy process, since this "n=1" discourse is "incommensurate" with the "n=many" orientation of policy discourse. Again, similar arguments are involved in the argument that it is not possible to change the registral features of legal discourse, religious discourse and so on, for instance as recommended by the Plain English movement, without significantly altering crucial aspects of the meaning, in particular interpersonal meaning (Tenor) (e.g., Bhatia 1983, Candlin and Maley 1994).

One of the key implications of these kinds of arguments for research on shared decision-making is that if decision-making is a complex context that varies in multiple dimensions in the way described above then there are dependency relationships and default/marked types of relationships between its dimensions. It is not enough to teach or research the dimensions as if they were independent. This conclusion needs to be taken more seriously in research on communication and decision-making in medicine, including research already using "parallel" coding of consultation transcripts (Ford et al. 2000) and research on framing effects in the presentation of risk information, to name just two examples (Tversky and Kahneman 1981, Lobb et al. 1999)[1].

[1] The literature on "framing effects" recognises the phenomenon of semantic interaction, but tends to have a limited view of which elements of messages and contexts interact. For example, "You have a 30% chance of the cancer coming back" constructs a negatively framed risk, but it *also* portrays cancer as an agent, and subsequent illness as the same cancer returning, whereas in the positively framed version, "you have a 70% chance of cure" (after Lobb et al., 1999), the semantics of agency and identity do not compound the "negativity" in this way. It is therefore misleading to attribute any effects of such framing to differences in polarity alone, as is often done.

5.4.4 The parametric approach to context and the definition of shared decision-making

The approach outlined above seeks to provide a set of higher-order categories which operate in all contexts, and which can help identify the typicalities and the boundaries of shared decision-making in HIV. These can then be calibrated against the particularities of grammatical and interactive choices. For instance, the social category of agency relates quite closely to the domain of contrast of agentive role, in Tenor.

Table 5.1 Parameters of Tenor typically associated with different styles of decision-making

Shared decision-making	***Informed Choice***	***Paternalism***
SOCIAL HIERARCHY		
Hierarchic: advisory/non-hierarch	Non hierarcharchic	Hierarchic: non-discretionary
Repercussive	Neutral	Repercussive++
(may be Undeclared)	Declared	Declared
Mutable: phase shift	Hierarchic: Mutable: role changes	Immutable
AGENTIVE ROLE		
Civic: office&rights/expertise	Civic: office&rights	Civic: office&rights
Reciprocating: equal/complementary	Reciprocating: complementary	Non reciprocating
SOCIAL DISTANCE		
Shared cultural capital technical	Shared cultural capital-tech	No shared cultural capital – tech
Shared cultural capital – social)	Shared cultural capital-social	(Shared cultural capital social)
(Shared local history)	(-)	(-)
(+Weak classification)	Strong classification	Strong classification
Weak framing	Weakish frame	Strong framing
(Multiplex network)	(-)	(-)

Note that the contextual configuration associated with shared decision-making is redeemable even from a very minimal exchange such as the above extract from Consult 29.

It is possible that shared decision-making will turn out to be the most complex of these three types of context, with the most complex texts (in a Hasanian sense), and this may have something to do with how difficult it seems to be to achieve shared decision-making in practice, even by those who set out to do so (Elwyn, Edwards, Gwyn and Grol 1999). Is this saying anything more than that shared decision-making involves more participation from the patient (if indeed it does require this?) Or that it is more dialogic in mode, therefore it is harder for professionals to direct the style of the decision-making consultation (SDM), because they are attempting to draw back from directing the decision-making itself? Probably these factors are involved in making shared decision-making a difficult context to practice, as it is a difficult context to capture conceptually. However there is something more in the claim that it is a complex context in the technical sense (Hasan 1999 esp pp 249-273). Hasan's claim is that the relation between the contexts that make up complex contexts may vary in meaningful ways and that it is important to be able to specify these different relations, cf. the notions of genre combination (e.g., Martin 1985), and genre hybridity (Bhatia 1993) which tend not to emphasise the different ways in which contexts combine with each other.

In HIV and other contexts, decision-making may construe patients and doctors as both having active agentive roles, or as one having a passive role and the other an active role. The distribution of agentive roles in a decision-making context must be understood as reciprocal if the interaction is to qualify as shared decision-making. This would be part of any definition of shared decision-making. Such a definition can be specified more delicately from the context networks, in terms of whether the reciprocal roles are complementary or equal, and so on. But there are reasons to think that we are working more towards *recognition* of shared decision-making than towards its *definition*. Crucial to the present study is the question of whether doctors and patients are both semiotic agents, or this role is largely confined to the doctor, or attributed to some third party. To examine in detail how this plays out in consultations, semantic strategies and grammatical patterns representing and enacting agency are examined in the next chapter. This move from context as a separate system to the interlocking systems of semantics and grammar constitutes a move to recognition rather than definition.