6

Agency and alignment

> Against the idea of an active individual whose actions comply fully with the goals of authorities, it becomes necessary, in the interests of self-determination, to articulate another form of agency, one that can negotiate (and where necessary challenge) the subtle ways in which control is exercised in this domain.
>
> Race et al. (2001: 6)

6.1 Aims of this chapter

As indicated in earlier chapters, HIV medicine is a context in which patients tend to have an active agentive role, although this is not always guaranteed, and indeed merely maximising patient control across all phases of the consultation is not the most appropriate way to achieve shared decisions (contra Charles et al. 1997). In analysing HIV medical decision-making, there are crucial tensions between construing patients as passive recipients of instructions, as passive recipients of information, or as active participants who are involved in proposing, evaluating, deliberating on and enunciating decisions. Such construals imply reciprocal tensions regarding the role of the consulting doctor, and may obscure the role of third parties, including community media, patients' social networks, clinical consultants, professional and institutional guidelines, and so forth.

The discussion of complex issues such as the best choice of HIV treatment is always likely to involve conflict of some sort, and the potential for such conflict increases as the role of the patients as a semiotic agent is expanded. If such conflict is not located and resolved, any treatment plans made may be inappropriate for the patient's circumstances, or be poorly accepted or poorly understood by the patient, which in turn is likely to result in poor adherence and drug failure (see chapter 2). These tensions often play out as palpable conflict in doctor-patient consultations, and in the research and policy literature on doctor-patient interactions.

As established in earlier chapters, there is a need for a more detailed description of the linguistic reflexes of the social theoretical concept of agency – one which is sensitive to what agency means in particular social contexts and where agentive relations may be complex, as the quote from Race et al. above implies. Such a description needs to account for the way that different discourses may be drawn on in a given context, producing and reflecting tensions over how agency is distributed and displayed in that context. Thus, when examining the construction of agency in HIV decision-making, it is crucial to examine also the alignment between speakers with respect to the construction of agency, as well as their alignment in terms of discourses of health and their respective perspectives on HIV and its treatment.

Departing from Charles et al.'s (1999a) model of decision-making styles as a three-point cline, Chapter 5 described shared decision-making as differing from unilateral decision-making in terms of the contextual constructs of Field, Tenor and Mode, finding that it is largely the Tenor of the context that makes shared decision-making distinctive. Within the construct of Tenor, one of the central features of shared decision-making is that doctors and patients are construed as having reciprocal agentive roles. But as Chapter 5 showed there are limits and contradictions in the ways patients are able to enact such agentive roles, such that their agency tends to be masked, or mitigated, for instance by taking certain options in the sequencing of moves that enact the social process of HIV treatment decision-making. In the current chapter I propose a more detailed description of the textual representation of agency, which aims to account more fully for the sense of agency that is conveyed by different ways of realizing moves in the decision-making process, and by different ways of setting up the discourse environment in which decision-making takes place.

In this chapter I take an approach similar to van Leeuwen (1996). Like van Leeuwen, I set out to account for the type and distribution of socio-semantic functions, such as semiotic agent, rather than grammatical functions for their own sake. But I refocus this approach in four related but distinct ways. Firstly, I focus on the *stratal alignment* of sociosemantic categories – i.e., the way in which they respond systematically to patterning at other strata, such that agency in HIV decision-making may be construed in quite different ways from its construal in other contexts. Secondly, I attempt to account for the interrelatedness of the *representation* and the *enactment* of agency, demonstrating how each conditions the other. Thirdly, I stress the *logogenetic perspective*, looking at how agentive roles that are attributed to doctors and patients (and other social and semiotic agents) change from moment to moment, and from phase to phase, even though they may also have a cumulative value across a whole decision or consultation. Fourthly, such construals are achieved through negotiation and contestation, and I stress the *mutual alignment* of doctors and patients with respect to the discursive positions that are instantiated as their interaction unfolds. I will expand briefly on each of these foci in turn.

stratal alignment

Although sociosemantic categories are the key categories we respond to as language users, these categories are contingent on contextual and grammatical variables. A sociosemantic account therefore covers the interpretation and explanation of interaction best when supported by semi-independent contextual and grammatical analyses, especially since descriptions of grammar are currently much better developed than semantic descriptions. Arguably, context descriptions are also better developed than descriptions at the semantic level. So it makes sense to do independent analysis using relevant aspects of these constructs to tease out as much of the patterning as they can cover, see what they leave unaccounted for, and then hypothesise about further patterning at the level of semantics (cf. Firth 1957). As van Leeuwen argues (1996), there is no neat fit between sociological categories and grammatical categories such as agency, and it is important to drive the analysis from a sociosemantic point of view. But it is possible, and valuable, to show how grammatical patterning makes a certain contingent contribution to the patterning of

agency, which is related to the sociosemantic patterning but not in an isomorphic way, and which is in turn contingently related to the patterning of agency in the context of situation, although again not in an isomorphic way. The textual patterning of agency is thus realized according to particular stratal alignments typical of the context in question (cf. Halliday 1973, Thompson 1999, Iedema and Degeling 2001).

To illustrate the importance of stratal alignment, if a senior hospital administrator, in a work context, talks about "doing it myself", and a patient also talks about "doing it myself", a straightforward lexicogrammatical description would have to treat them as equivalent in terms of agency. But quite different senses of agency may be implied – enhanced agency for the patient and constrained agency for the hospital administrator. For the senior administrator, "doing it myself" contrasts with delegating or "telling someone else what to do". For the patient, "doing it myself" contrasts with "being told what to do" (e.g., in Race et al.'s text extract). Here the same lexicogrammatical choices of agency are used to realize different semantic paradigms (+/- autonomy for the patient, and +/- effectuality for the health administrator), but we can only specify how this works from an understanding of the specific alignment between these three strata for each context. (Compare this with Iedema and Degeling's (2001) discussion of how bureaucratic discourse has a distinctive 'division of labour' between the different linguistic strata for managing interpersonal conflict.) These examples illustrate that we need to show how realization works not by linking up *linguistic items* at different orders of abstraction but by linking up *paradigmatic systems* at different orders of abstraction.

The main point here is that in order to give a satisfactory account of the context it helps to posit an intervening layer of patterning between the context and the grammar. But it would be counterproductive not to make use of the grammatical descriptions available or to subsume them in the semantic description. For instance, keeping the grammatical and semantic accounts sufficiently separate helps in describing how and why the meaning potential of "shouldness" (cf. Findlay 1970) tends to be experientialised in administrative contexts, i.e. realized through experiential grammatical resources (e.g., "It is necessary to..") whereas in some other contexts it is more likely to be realized through interpersonal resources ("You must.." or "Do you think you'd be able to.."), where the many different ways of

handling shouldness construe important differences in context (Iedema 1997). So it is too with the semantics of agency, which is arguably "interpersonalised" in the context of joint decision-making. Therefore the approach in this thesis has been to identify the distribution of options from well established grammatical categories, as well as to identify, in a more intuitive way, semantic contrasts in agency that appear to be consistently contrastive in HIV medical decision-making, and which appear to drive the sense of patient participation in (and control over) treatment decision-making and dosing. It will turn out that these contrasts are often over and above the contrasts available in the grammar alone.

logogenetic perspective

To establish what such contrasts are, and to then examine when they are used in treatment decision-making and by whom, it is essential to focus on the logogenetic unfolding of the interaction as a social process. Where SFL tends to examine logogenesis with renovated tools for schematic (or diagrammatic) analysis, the logogenetic account is the fundamental perspective of Interactional Sociolinguistics and related approaches, including some approaches within CA. As outlined in chapter 4, from such perspectives, agency is examined according to the way in which interactants *emerge* as agentive or passive figures and, more particularly, largely in terms of the extent to which they direct the dialogue under examination on the one hand, or help shape it more by colluding with the another person's agenda on the other hand (e.g., Maynard 1991, Sarangi and Clarke 2002, Peräkylä 2002). Iedema and Degeling (2001) point out that this focus on the unfolding interaction often comes with an eschewal of the systematic description of lexicogrammatical features, although this is not always the case, and indeed it is possible and valuable to combine the schematic and the logogenetic perspectives, as they do in their paper, and as I attempt to do here.

enactment and representation

Bringing these two perspectives together implies looking at the relationship between the enactment of agency and its representation. For instance, Peräkylä (2002) suggests that if doctors display the evidential basis for their claims then patients will

assume some agency in the realm of clinical reasoning. But it might be necessary to qualify this association, and an important place to start is with a systematic examination of whether being represented in an agentive figure in the surrounding discourse also encourages patients to perform as agents of clinical reasoning.

Of course the functions of representing and enacting, although distinct principles, are always co-present in verbal interaction, so it is important to see them as, again, indeterminate and contingent perspectives on meaning. I draw on my analysis of generic phase (see chapter 5), and on some fundamental aspects of interpersonal grammar (see chapter 3), as well as the representational resources foregrounded here and in chapter 4, to throw some light on the relationship between being *represented* as an agent and *acting* as an agent.

To understand the contingent nature of construing agency in interaction it is important to recognise that a social actor may only need to enact agency or be portrayed as agentive at certain key points or for certain key actions in order to have a dominant agentive role, as Atkinson argues in his discussion of how evidentiality is constructed in medical case presentations (Atkinson 1999, 1995). Atkinson remarks that the repeated use of the passive voice (a key representational resource for construing agency) is in itself unremarkable since this is the 'normal' mode of case presentations (cf. Anspach 1988), but that it becomes significant as a background of impersonalised objectivity against which instances of the active voice are interpretable as attributions of personal agency, responsibility or opinion[1]. In a similar vein, Linell points out (1990: 158) that "you need not talk a lot or make many strong moves, as long as you say a few, strategically really important things". Linell describes such "strategic moves" as one of four kinds of dominance in interaction, which also include the "amount of talk" (purely quantitative dominance); "interactional dominance", through which he deals with the initiating versus responding features of participants' contributions and the degree of symmetry with respect to these (cf. Linell et al. 1988)[2]; and "semantic dominance", which Linell

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[1] Cf. Halliday's notion of foregrounding (1973), which requires "motivated" prominence.

[2] The approach proposes an Initiation-Response structure (IR structure), from which an IR index for participants may be calculated. This coding scheme is similar in some ways to Sinclair and Coulthard (1975), and to Eggins and Slade (1997), but it is not configured for a particular context/ register such as education (Sinclair and Coulthard) or casual conversation (Eggins and Slade), and it also allows

describes in terms of control of topic, or perspective on topic. My discussions of the way representational resources are deployed to foreground or background doctors' and patients' agency can be seen as a slightly different approach to "semantic dominance". The key point for this chapter is that an analysis of representing agency always requires some degree of analysis of how agency is enacted, and vice versa.

mutual alignment

As outlined in chapter 1, the discussion of mutual alignment, like agency, has covered a wide range of concerns which often overlap but in which apparent synonymy actually masks a number of fundamental ambiguities. Exactly what is *aligned* in 'mutual alignment'? Propositions? Points of view? Persons? Bodies? Attention? Coding orientation? All of these, and more, have been proposed or can be inferred in the literature on alignment and related constructs.

Drawing on insights from Goffman (Goffman 1974, 1981), CA is the research paradigm with the most cohesive body of theoretical and empirical work in this area. The idea of sequential implicativeness or sequential relevance is an important plank of any discussion of alignment: recall Schegloff's injunction to treat discourse as "something produced over time, incrementally accomplished, rather than born naturally whole out of the speakers' forehead" (Schegloff 1982: 75). Additionally, CA explicitly models the structure of talk as a series of responses, and provides for each turn to be seen as an opportunity for interactants to move together or move apart. This approach profits from a systematic analysis of the linguistic resources and institutional pressures shaping such sense-making (Ochs, Schegloff and Thompson 1996); a key principle which links these perspectives is Gumperz's notion of contextualisation cues, outlined in chapter 5. In addition, the power of a focus on temporality is increased if we consider it more in terms of logogenesis and the accumulation of meanings, rather than just sequence or adjacency. The reason for

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one to classify abstract semantic/pragmatic features as initiating or responding. Thus with Linell's model it is not necessary to subdivide turns physically (e.g., temporally) into response-part and initiative-part, although this may be done in those cases where it is the best analysis (cf. Markova 1990b).

this is that the relevance of a particular turn to the overall meaning of an interaction does not necessarily peak at the time of its utterance.

A number of empirical CA studies make important insights about participants' use of "resources for displaying to each other a congruent view of the events they encounter in their phenomenal world" (Goodwin and Goodwin 1992) and for co-constructing such shared worlds (Goodwin 1994) (Goodwin 1995) (Heritage 1984, Jacoby and Ochs 1995, Maynard 1986).

However, most of the work on alignment in CA is concerned with the *display* rather than the *definition* or *analysis* of agreement and of shared expectations. For instance, in the classic asparagus pie assessment analysis (Goodwin and Goodwin 1992), Dianne says the asparagus pie was "so good", and Clacia then says "I love it" before Dianne has finished her assessment. Clacia is *displaying* the fact that she has a similar assessment, and thus displaying her alignment to Dianne's view of events, and of the context they are mutually engaged in constructing. But Goodwin and Goodwin do not say what would comprise misalignment: if Clacia says she hates asparagus, but still orients to the context as assessment and displays her fine tuned tracking of the "emerging structure of the speaker's sentence and the activity that the speaker is progressively entering" (Goodwin and Goodwin 1992: 182), is she not still well aligned? What requires more theoretical and empirical attention at this point is the way in which being non-aligned or mis-aligned means that the interactants in question are not merely disagreeing, but rather are operating with different frames of reference, choosing from different systems of choice. In examining the way doctors and patients participate in treatment decisions, the most crucial dimension to capture is *this* type of discursive misalignment between participants, or their overall degree of semantic fit. What I am concerned with here comes close to what S.Candlin (2002) calls "comprehensive coherence" and what Linell (1995) discusses in terms of miscommunication. Linell's gloss of miscommunication is "talk non-deliberately generating or mobilising and sometimes leaving discrepancies between parties in the interpretation or understanding of what is said or done in the dialogue" (Linell 1995: 177, cf. Aronsson 1991, cited in Linell 1995).

Miscommunicative discrepancies may emanate from social conflict (cf. Grimshaw 1990), or it may arise in maximally co-operative, symmetrical and

harmonious interactions. Participants may display their awareness of and orientation to such discrepancies and mark their convergence and/or divergence (Iedema and Degeling 2001, Tannen and Wallat 1993, Goodwin and Goodwin 1992), including, minimally, as "silent disagreement" (Aronsson and Sätterlund-Larsson 1987); or they may *generate* and *mobilise* significant discrepancies of interpretation while *displaying* agreement and perspective sharing, as we will see below.

White (White 1999) discusses alignment in terms of heteroglossia, stating that "all texts reflect a particular social reality or ideological position and therefore enter into relationships of greater or lesser *alignment* [my emphasis] with a set of more or less convergent/divergent social positions put at risk by the current social context". White's Engagement Theory explores "relations of alignment, rapport and empathy, versus relations of separation, alienation, antagonism" (White 2000) and would thus seem very relevant to our discussion of shared decision-making in HIV medicine. But again, as can be seen from the fact that alignment is positioned with empathy and contrasted with antagonism, the concern is mostly limited to ways that speakers *display* their alignment with other speakers and other points of view. The linguistic resources examined, in particular modality and projection, are interpreted in terms of their interpersonal function, in particular the opening up and closing down of the negotiability of positions expressed, on a heteroglossic-monoglossic continuum. Whether the linguistic behaviour captured by engagement analysis captures anything about the positions themselves is unclear. Speakers who score most highly on features of alignment or engagement are often those who do not actually reveal their views for scrutiny, as illustrated by President Clinton's high alignment speech style during his election campaign (Sutch 1993).

In short then, it is necessary to examine whether doctors and patients are talking about the same things in the same terms and with the same sense of who has what discursive rights. That is, it is crucial to test the extent to which the "ratified, joint, current, and running claim upon attention" produced in talk does in fact lodge doctors and patients in an "intersubjective mental world" (Goffman 1981: 71). I bring these perspectives together in this by taking up the view of agency as the "socioculturally mediated capacity to act" discussed in chapter 4, using examples from my corpus to illustrate how key contrasts or grades in these dimensions of

agency are construed in HIV decision-making. For each dimension I will also specify the critical areas of symbolic patterning that are responsible for textual mappings made along that dimension, in terms of their stratal, metafunctional and instantial location. Semantic patterning is presented as a set of mediating links between the types of contextual configurations that can be recognised and the types of lexicogrammatical choices that construe them – i.e., as the "kinds of statements necessary to carry description between context and lexicogrammar, and lexicogrammar and context" (Butt 2000a). This approach will allow me to revisit some explicit claims and some implied claims (e.g., Race et al. 1997, Charles et al. 1999a) about the role of agency in construing joint decision-making.

The rest of this chapter is organised into two parts. In the first part I build up a network that sets out the key dimensions and contrasts within them, and where appropriate I present summary descriptive statistics about the features in question. In the second part I use the network to examine particular instances of decision-making at length.

6.2 Building up the network

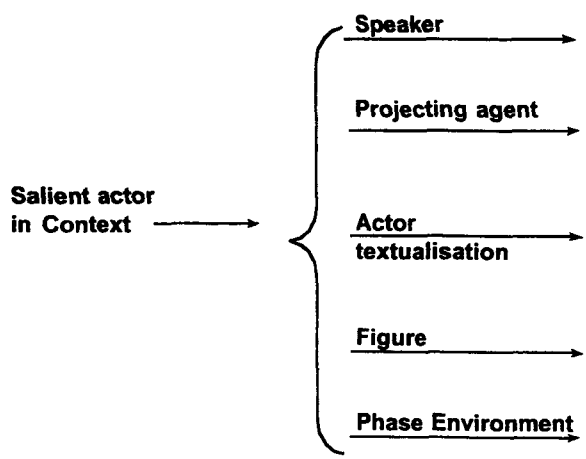

Figure 6.1 Point of origin and five main domains of contrast

Figure 6.1 shows the point of origin for this sociosemantic network, and five key domains of contrast which are crucial for interpreting the discourse environment of any consultation as one which depicts the patient as agentive or as passive with respect to making decisions about their treatment. A fundamental consideration in establishing whether a certain social actor is construed as having an agentive role in decisions about HIV treatment is the extent and type of their presence in the existential fabric of the interaction. If they have a textual presence, we can go on to examine what kind of presence that is in terms of the other dimensions described below, such as what kind of activity they are shown as involved in. If they have only an oblique or latent textual presence, it is more difficult to establish what kind of agentive role is being construed, but there is still important textual evidence that can be drawn on (cf. van Leeuwen 1996, Butt 1988b).

For example, patients may be typically represented as centrally involved in some kinds of activities, but in others they may be represented as either less centrally involved or as not involved at all. Thus, it is important to track ACTOR TEXTUALISATION with respect to any actor relevant to the context, against each FIGURE or "quantum of change" (Halliday and Matthiessen 1999) being depicted (cf. van Leeuwen 1995), and against the person putting forward such a depiction, viz SPEAKER, and in addition against any other PROJECTING AGENT that the speaker might depict as having semiotic responsibility for how an actor is textualised or not textualised. In some cases, 'exclusion' from some types of Figure and not others can be considered to reflect a particular expectation or ideology about the roles of social actors, among an array of alternative expectations. Such textualisations appear to vary with the role expectations associated with different types of decision-making in medicine, but since these themselves vary by phase of decision-making (see chapter 5) it is important to track the four dimensions already identified against the contextual variable of PHASE ENVIRONMENT.

Finally it should be stressed that it is important to be able to make arguments on the basis of the social actor's semantic presence in a text carrying over to passages where their textual centrality or even textual presence has diminished. The category

of projecting agent, treated as a prosodic semantic variable, has an important role as evidence in arguments about the way an actor's presence carries over to messages that are not their own utterance (Bakhtin 1986). The notion of a 'carried over presence' was illustrated in chapter 4 in the reanalysis of data from Race et al. (1997), and is illustrated further below in sections 6.4 and 6.5, with respect to the current dataset.

6.2.1 Actor textualisation

The point of this section of the network is to establish whether salient social actors are textualised as actors, as some other entity (as implied in the representation of some process), or not textualised at all. This part of the network is necessary as a prerequisite to examining what kind of agentivity different social actors are represented as having. This part of the semantic network is necessary precisely because being textualised as an entity is not a requirement for an actor to be construed in agentive terms. As van Leeuwen (1996) demonstrates, texts routinely allocate agentive roles to non-textualised entities. The analysis of the nature, extent and distribution of agency therefore cannot proceed by examining the textual treatment of already textualised entities, either at the grammatical level (Participants, Circumstantial elements) or at the semantic stratum if we take a textualised notion of entity such as Cloran's Central Entity (Cloran 1994).

In the node of the network marked ACTOR TEXTUALISATION I follow van Leeuwen's network quite closely (van Leeuwen 1996). An actor may be *excluded* from the text or interaction altogether. An interesting example is that across many of the consultations in my corpus the patients' work colleagues are excluded from the discussion about treatment.[1] If an actor is not excluded from the whole text, they may be *suppressed.* An example is in extract a) below, in which case the patient does not appear in the message in question, and cannot reasonably be inferred through ellipsis etc., but can be inferred from the context as a potentially relevant participant to the

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[1] Exclusion of colleagues does not take place in all consultations, and it is not necessarily a problem when it does happen. The point is that it may be possible to de-naturalise the exclusion of certain actors in order to examine whether there are relevant social consequences.

action of taking pills (though in order for this to be a well motivated category for the current purpose it might be more helpful to think of the suppressed actor as having some possibility of cohesive relations in the present text or phase).[1] If the actor is reasonably to be inferred but is not textualised as such, then they are *backgrounded.* This would include realizations such as non-finite clauses as in b) below, "just to simplify things", where the speaker can be inferred as the actor who is simplifying. The most explicitly textualised social actor is *visible*[2] in the text though not necessarily a grammatical participant (see below).

a) 2_65_2 D *Um I'd want to do something about the pills*

b) 62_35 D Um, but there's- there's a question mark about it|| because, um, <<just to simplify things>> basically um, ||when, um, you start off with- if you start off with a normal T-cell count, ||there're individual T-cells [[that are primed [[to deal with specific infections]]]].

These choices are represented as early options in the network, as follows:

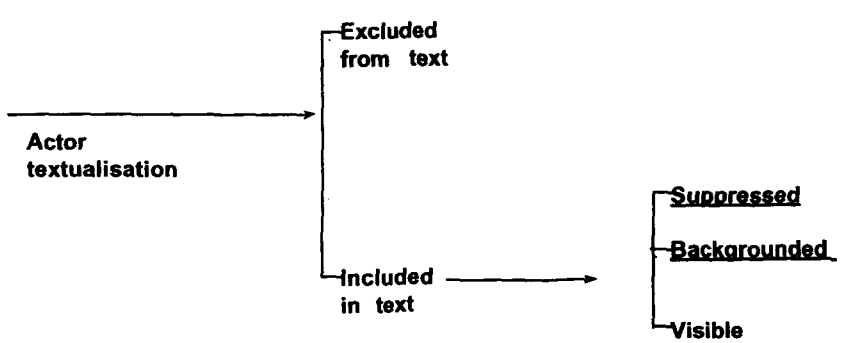

Figure 6.2 Actor textualisation network fragment

[1] cf. Lemke's (Lemke 1985) notion of cohesion between items as a question of when, rather than whether.

[2] The distinctions between excluded and visible are a matter of degree. I have divided this space into four degrees where van Leeuwen has three.

6.2.2 Speaker and projecting Agent: framing the representation

The node labelled SPEAKER is required in order to tailor the network to spoken/dialogic texts. It answers questions about which interactant construes issues in terms of which agency patterns: for instance, who or what the patient identifies as agentive in their health care, or as agentive in other aspects of their life. This is then central to an examination of whether the doctor and patient are aligned in their framing of the issues.

Recognition rules for the choice of speaker are fairly simple and consist of noting whose physical voice is being heard to produce a given message or turn (or part thereof, for co-completed utterances). In the context of HIV treatment decision-making the question of who gives phonetic or (occasionally in this context) graphetic expression to a message is probably most crucial at the phases of Declaration and Enunciation, since as discussed in Chapter 5 these phases form the nub of this context of decision-making. In most cases this question is a matter of 'necessity' rather than 'sufficiency': phonetic responsibility is never sufficient for a message to be said to have been voiced by one party or another (or shared by both). These choices are represented in the network as follows:

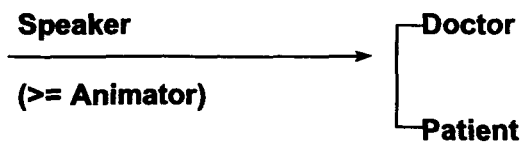

Figure 6.3 Speaker network fragment

This part of the network is necessarily more general than the rest, and would be required for analysing dialogic texts whether the rest of the analysis were about agency in HIV medicine or about something completely different. In a sense it is 'grafted on' from elsewhere in some broader sociosemantic map, or perhaps a better

analogy would be of a large map kept partly folded so that two non-contiguous parts can be consulted simultaneously. Since we are not concerned with spoken interaction between other parties there are only two options of speaker, doctor and patient, provided as in c) and d) below.

c) 10_84_3 D And, and how are you going with the saquinavir, with .. taking it with the grapefruit juice or the food or whatever?
d) 10_85_1 P Well this is where I've been a naughty boy..

The node PROJECTING AGENT answers questions about responsibility to do with the content of the message; it identifies key ways of showing who has a point of view, or whose potential point of view might be relevant (in the case of views that are invoked but never specified). For instance, a doctor might represent a patient as legitimately having a view, for instance by asking simply "What do you think?", but this is rare in my data. More commonly a potential view is projected on behalf of the patient, which the patient can choose to identify with or not, as in example e) below.

e) 59_123_1_1 D If you say to me,
59_123_1_2 I'd like to get down to um less than a thousand,
59_123_1_3 but I don't really mind
59_123_1_4 if I get down to zero,
59_123_1_5 then I will say to you,
59_123_1_6 take these two drugs, 3TC and AZT.

In this example, the doctor projects the voice of the patient in clauses 2, 3 and 4. One effect of this strategy is to objectify a particular clinical goal as the patient's (potential) view. More particularly it represents the patient's view as a desire, but also as something that the patient can and will externalise as speech, directed at the doctor as some kind of request or directive. In clause 6 the doctor projects her own view, as what she "would say" in response should such a view be put forward by the patient. I am using this example in a simple way here to illustrate choices in who is represented from message to message, topic to topic etc. as the holder of a view, but we can begin to see from this short extract how such choices also serve in a more complex way as discourse strategies for building a sense of agency and a sense of choice on the part of the patient, while at the same time structuring and constraining

the available choices and displaying their contingencies; a more detailed discussion of this appears below.

Choices with respect to who projects, as distinct from who articulates, a given message are represented in the network as follows:

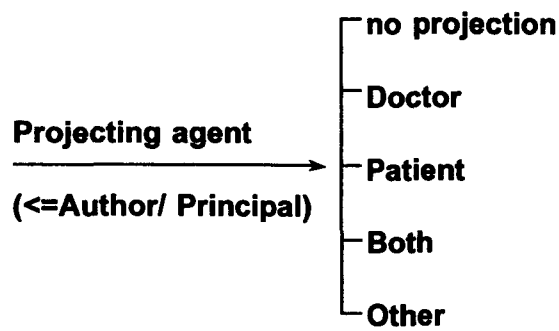

Figure 6.4 Projecting agent network fragment

At the node PROJECTING AGENT then, the term "projecting" refers to the semantic phenomenon broadly rather than to any one grammatical means for achieving projection. Projection requires an analysis in terms of the interaction between speaker and projecting agent, informed by Goffman's notion of production format (Goffman 1981, Levinson 1988). In the example above the doctor would be the Animator, Author and Principal of her own projected irrealis treatment recommendation, which she represents as contingent on the patient's view. The patient is represented as the Principal and the Author of this (possible) view. Recognition rules for identifying a Projecting Agent include:

f) Senser in a projecting clause

37_44_1 P And, he wanted me to use Bactrim.

g) Sayer in a projecting clause

37_44_2 P I said
37_44_3 oh, I'm already taking Bactrim sometimes.

h) Zero quotative

37_52_2 P Yes, but why did they put you on Bactrim? ((projecting voice of pharmacist in conversation with himself))

i) Sayer/ Senser in embedded verbal and mental clauses that function as projections

37_69_1_2 D the point is about PCP [[that we know ||that the risk goes shooting upwards once you drop below two hundred, right]]?

j) Circumstance of Angle

37_73 D According to our- OUR set of rules, you should be on Bactrim.

In addition, although they are not represented as Projecting Agents, when there is an implied Sayer/Senser in autonomised utterances (van Leeuwen 1996), in modalised and modulated constructions, this may be linked up to social actors who have been previously textualised, or contextually salient but not textualised, especially where there are cohesive links in the text which support the construal of a projecting agent other than the Speaker, or a separation of Speaker-now from Speaker-as-projecting-agent.

Where there is no projecting agent the Speaker represents himself as the Animator, Author, and Principal of the message, in Goffman's terms. Where there is a projecting agent, the speaker may be distributing the different production roles to self and others in a number of ways:

1. If Speaker and Projecting Sayer/ Senser have the same linguistic identity[1], then Animator, Author and Principal are conflated (or to put it another way, the Speaker role remains unified). This happens whether the projecting clause is a quote or a report:

k) Use these eye drops
l) I'm tempted to say "Use these eye drops" (quote)
m) I suggest you use these eye drops (report)
n) I think I said to use these eye drops (double projection/ modality)

[1] The speaker and projecting agent must "have the same linguistic identity" rather than being the same entity, because entity and identity cannot be taken to have foundational status here, and the construal of different aspects of identity draws on these patterns of reference. So, for instance, if I say "Moore 2000 argues.." this has a different status from saying "I argue".

2. Secondly, if Speaker and Projecting agent have a different identity then the conflation of production roles depends on whether the projected message is projected as quote or report. Author and Principal are always conflated in quoted speech. This is also true for projected thought, which is nearly always in the first person, e.g., "I thought to myself 'No, not again!'" (cf. Matthiessen 1995). Thus, if Speaker and Projecting Agent are different and the projected message is a quote, the Speaker is putting both the Author and Principal roles of the projected message onto another party.

o) If you say to me, ||I'd like to get down to less than a thousand...
p) If you're thinking || I'd like to get down to less than a thousand
q) If you tell me || you'd like to get down to less than a thousand...
r) If you think || you'd like to get down to less than a thousand

In example o) above, from Consultation 59, the speaker (the doctor Karen) is arguably constructing the patient, Joan, as the Principal and the Author of this view, and herself only as the Animator. My way of analysing this is probably departing from Goffman's model, and certainly from Levinson's development of it, but it provides a useful frame for describing what appear to be salient contrasts in the context of HIV decision-making. However, it should be stressed that this analysis of how speakers attribute views and statements to other social actors and project other voices – in particular "potential" voices – does not imply that such views are held by these parties, or that such statements have been or will be made, merely that that is how the views, claims, etc. are framed. It should also be stressed that projecting a message as the view of another party, even if it is a verbatim quote, is always a recontextualisation and never a reiteration of a speech event (Bakhtin 1986, Linell 1998), so there is always some authorial responsibility, with respect to the current message, in invoking the utterance of another (Baynham and Slembrouck 1999).

It is interesting therefore to observe that in a subsample of 2,000 messages from the current study, doctors and patients used projection at approximately the same rate, and that both doctors and patients were more likely to project their own voices in some form than to project the voice of another party, although this tendency was more marked among patients (see Figure 6.5 below).

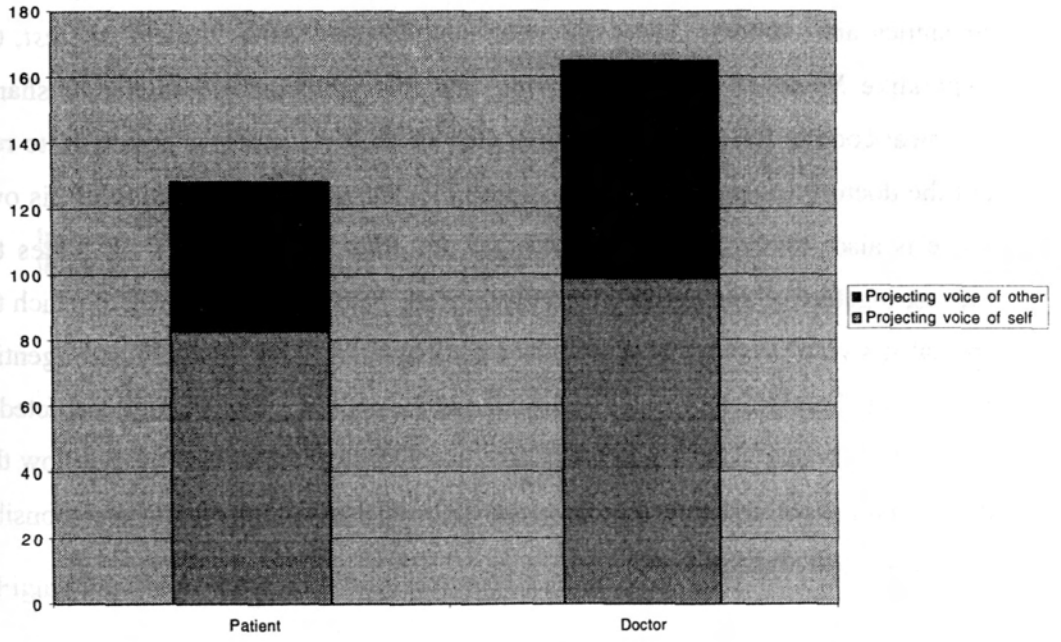

Figure 6.5 Network fragment, use of projection by speaker and by voice projected

For example, in Consultation 1 below, Philip is relating to his GP, Martin, what happened in a recent consultation with a specialist.

1_13	P	Okay.
1_14	D	What did ((name of specialist)) suggest?
1_15	P	Well um, obviously change the drugs. He suggested DDI...
1_16	D	Mm-hmm.
1_17	P	um, oh god... ritonavir, and I can't remember the other one... ah one's six pills twice a day, is that ritonavir?
1_18	D	Yes.
1_19	P	And the other one's one pill twice a day.
1_20	D	3TC?
1_21	P	No, it's a protease. It's not licensed, it has to be ordered I think

1_22 D Ah nelfinavir?
1_23 P Yes I think that could be it. Nelfinavir. Mm anyway ((discussjon continues))

In this segment, the treatment recommendation is presented as the view of the specialist, but the "voice" of the specialist is not represented through any one simple grammatical resource. The specialist's view is collaboratively reconstructed, by both the patient and the GP, and the symbolic resources for achieving the construal of this treatment option as a third-party suggestion are dispersed across the lexicogrammar, semantics and context. These resources include the Verbal Process *suggest*, the imperative Mood of *change the drugs*, and the contextual parameter of shared technical coding that allows a response such as *No it's a protease* at turn 21 to rule out the doctor's suggestion of 3TC at turn 20[1]. The patient's projection of his own voice is also involved (*I can't remember the other one*), and this facilitates the piecing-together of the specialist's probable view. Note too that the way in which the specialist's view is constructed presents a particular but rather indeterminate agentive relationship between the specialist, the GP and the patient. Who is being instructed to change treatments? This is left undeclared. In subsequent sections we will follow this doctor and patient's treatment reviews and their representations of who is responsible for which parts of the process.

6.2.3 Actor personalisation

This section of the network draws on van Leeuwen (1996). The issues at stake in the different representation practices accounted for in this part of the network surround whether the social actors in question are presented as persons or as some other kind of entity or role. Some discussion of these choices was given in chapter 4. In the present study, we are mostly concerned with how doctors and patients, as interactants, represent each other as practitioners of medical decision-making, and since the data is dialogic the textual resources for construing each other in different

[1] There is no grammatical marking of projection at turn 15. but its status as the projected locution of the specialist is clear from its status as a response to the doctor's question in turn 14, and additionally from the patient's elaboration with a clear attribution. This can be seen as a "zero quotative", except that interactive discourse considerations of ellipsis make the idea of zero quotative less meaningful.

ways lie largely outside the rich description of contrasts provided by van Leeuwen and shown in Figure 6.6 (though not entirely, as we shall see shortly), so this part of the network has not been presented in its full detail. (See chapter 4 for additional contrasts at greater level of delicacy.)

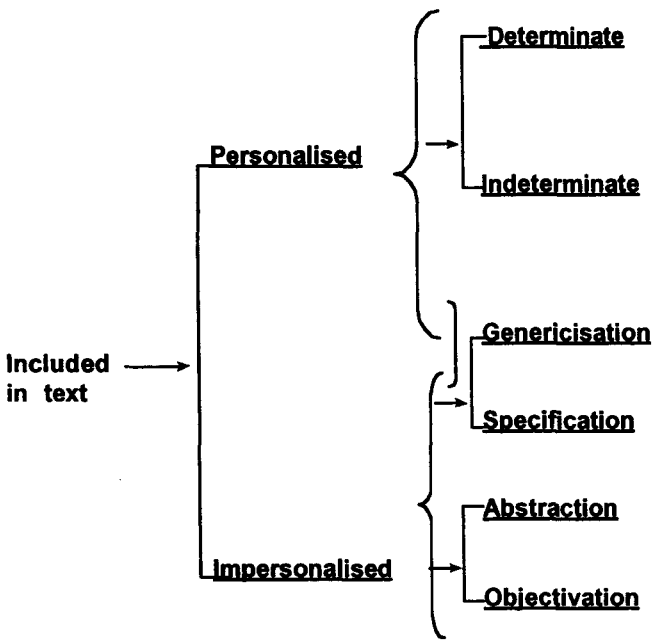

Figure 6.6 Personalisation of social actors network fragment

In the context of HIV medical interaction, the doctor and patient usually use first- and second-person pronouns to refer to each other, and these have characteristics of personalisation and impersonalisation. Where *impersonalisation* of the interacting party occurs, this does not have the force of an impersonal representation of a third party. For instance the people and processes (and equipment) involved in testing blood samples for viral particles and producing "viral load test results" are seldom personalised. The symbolic processing of humans and computers alike is generally represented only as "autonomised utterances", as in s) below, in which no people are involved in testing or in getting or giving the results, or t), in which human agency is involved in dispositive action on existing semiotic objects. My corpus includes occasional instances in which human actors act semiotically in the process of

producing viral load counts – either *objectivated* and *spatialised* as in u) or *personalised* but *indeterminate* as in v).

s) 56_269_1 D The results will be back
t) 72_44_2 D I'll try and get er urgent results back [in the next few days.
u) 43_19_2 P I was getting it done down at ((Hospital A))
v) 43_19_2 P and they said it was what four hundred and thirty...

Where social actors are *personalised*, the extent to which they are differentiated from each other is important. Crucial here is which mental, verbal and material acts are represented by doctors and patients as undifferentiated social actors (we/us/...), and at what point in the consultation such representations are made. It is particularly important to examine differentiation in the phasing of the consultation, which will be briefly illustrated here. (See also the extended discussion of Consultation 37 below for a consideration of the significance of representations which move in and out of differentiation status.) Example w) shows individuated and x) shows assimilated representation of the patient as a social actor in the phase Bearings. Example y) shows a personalised individuated self representation by a patient at the point of *declaring and enacting* a treatment decision. Example z) shows a doctor's use of a personal plural first person, which probably represents the doctor and the patient as individuals but could also construe institutionalisation, which in this case draws on *functionalisation,* also from a conflated Declaration and Enunciation phase. Notice that those tokens that are declaring and enunciating make the choice of individuation or assimilation more salient in terms of whether shared decision-making is being fostered or impeded.

w) 76_6 P I've just come for the blood results
x) 58_100 D And the antibiotic <u>we</u> give you to make it better, gives you? [DIARRHEA!].
y) 45_124_1 P Well I'm totally not, UTTERLY not willing to take AZT.
z) 15_144_1 D I'll give you a script and <u>we'll</u> start you off on some B12 injections and they'll be once a week. For six weeks and then <u>we'll</u> take it from there. The other thing I'd like to do is stop the d4T.

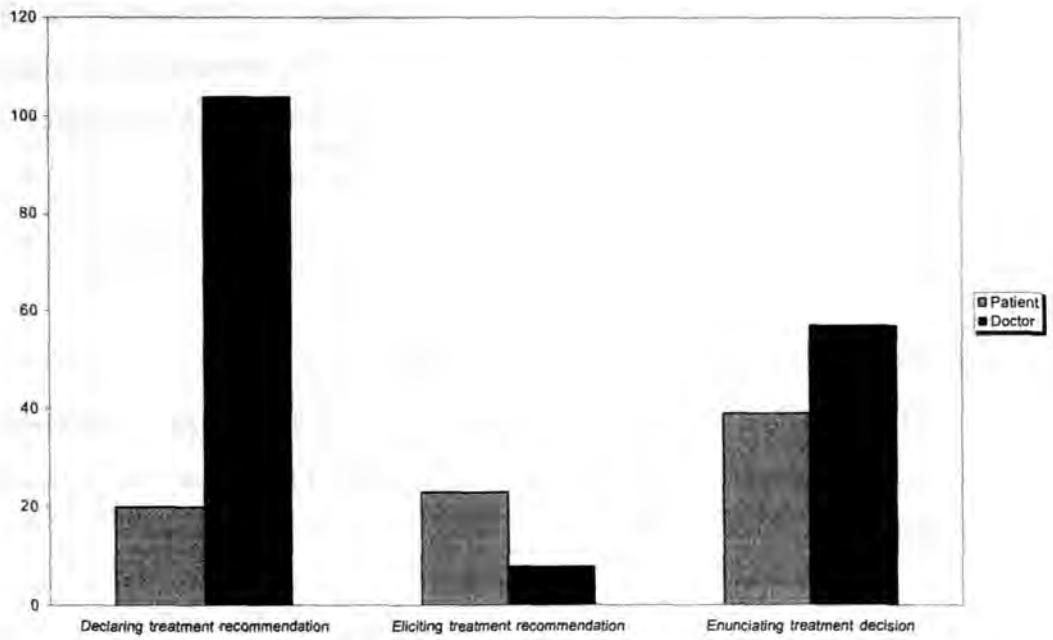

Figure 6.7 Instances of the moves Declaration, Elicit Declaration and Enunciation, by participant (entire corpus)

Figure 6.7 presents the number of times in the corpus that doctors and patients made the moves of declaring a treatment recommendation, eliciting the declaration of a treatment recommendation and enunciating a treatment recommendation. As the figure shows, doctors were much more likely to state a treatment recommendation or preference than patients were, and patients were more likely to elicit a recommendation from the doctor than doctors were likely to elicit a recommendation from their patients. Doctors were more somewhat likely to enunciate treatment decisions, but the most important aspect of doctors and patients behaviour in this regard was way in which enunciations were realized. Of the 38 Enunciations I described as being made by patients, most (25) comprised minor clauses indicating agreement to the doctor's recommended course of action (*OK*, *Fine*, *All right*, etc.). By contrast, when doctors enunciated treatment decisions (and these are not mutually exclusive options; a decision may be enunciated and re-enunciated), these tended to comprise directives ("So continue on your current medication for the moment") or

statements with a desiderative element, where the recommendation and enunciation come in a single move. Both of these ways of enunciating what a decision is taken to be construct the doctor as the semiotic agent responsible for the enunciation, since in every "Continue on your current medication" there is an unspoken "I'm telling you to ..." (cf. Baynham and Slembrouck 1999).

6.2.4 Role allocation and activation/passivation

The network section which deals with the way in which actors can be actively or passively represented is also drawn from van Leeuwen's (1996) network with some modifications.

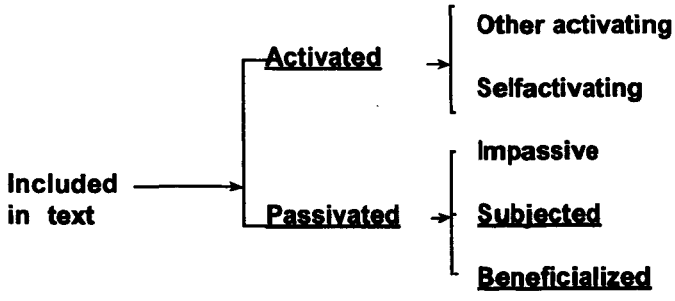

Figure 6.8 Role allocation network fragment

As in van Leeuwen's account, a social actor may be either activated or passivated. The linguistic resources (and thus recognition rules) for activation include mapping

the social actor onto the grammatical role of Actor as in a'), Senser as in b'), Sayer as in c'), Behaver as in d'), or Assigner as in e') and f')[1].

a')	37_178	D	Just, we can cut it out". -
b')	62_4	P	I was expecting actually worse results.
c')	3_13	P	And you said, come thursday and you should have the result.
d')	1_12	D	I might listen to your chest in a tick.
e')	37_132	P	It makes you really nauseous
f')	62_163	P	And what do you call long term?

Activation may also be achieved through *circumstantiation*: e.g., the Circumstance of Angle as in g'), h') and i'), Cause as in j') and k'), or Means as in l') and m').

g')	37_55	D	Yes, er, I'm just trying to, actually work out from the arrows down on the page.
h')	37_73	D	according to OUR set of rules, you should be on Bactrim.
i')	59_60	D	Our- the sort of way [[that we run on this]] is, [[if you've got a rate of a hundred thousand, ||I'm going to sit on your head||and make you take treatment, right?]]
j')	59 _6	P	you know, like I'm just about to faint from starvation
k')	59_460	P	I don't want to be lying around in a terrible fit from all three (drugs)
l')	59_610	P	I don't know exactly what you mean by the question
m')	37_127	D	I do not believe he ought to receive further treatment with this agent. ((quoting specialist))

Note that h') and i') incorporate the role of possessivation, which may imply activity where directionality is also construed. For example, "our rules" implies the regulation of behaviour, and from the context this activates the doctor/speaker as a member of the institution which governs the bodies of the sick. Example i') shows the agnation between representational practices of possessivation and participation ("our rules/way" becomes "the way that we run on this").

In g'), we see that the representation of the activation of social actors, even at clause level, is not simply an either/or matter. For instance, a circumstance of Angle can be included in addition to activated Actor. In this instance we have a representation which construes interpreting viral load results in sequence in the patient's record as an explicitly mediated action, in which the arrows are construed

[1] Note that Assigner, and Relational clause constructions in general, are weighted less towards grammatical features in terms of their sociosemantic construal of agency.

as symbolic tools that have some level of active participation in the process of interpretation along with the human sensor.

Activated actors may be represented as self-activating as in n'), o') and p') below, or as activated by another, as in q') and r').

n')	37_47	D	Did he come to that conclusion, (or did you have to tell him?)
o')	58_469	D	you actually have to get it into your head, that this makes YEARS of difference to your life
p')	58_460	P	I need to make sure that this is the right time.
q')	59_650	D	I'm going to sit on your head||and make you take treatment, right?]]

Passivated social actors may be either *subjected* as in n') or *beneficialised*, either materially as in o') or semiotically as in p') or ambiguously between these two as in q'). Passivation may be realized through the grammatical participation status of the social actor (n'-p'), but other strategies also occur, including representing them grammatically in terms of possession, as in q'). Here the social actor is activated to some degree by being represented as the potential holder of information, but by contrast with other ways of representing knowledge status, such a construal downplays the agency of the social actor in question, here the speaker/doctor.

r')	37_52	P	Yes, but why did they put you on Bactrim?
s')	59_275	D	No, I'll give you this one here, Indinavir...
t')	37_47	D	Did he come to that conclusion, or did you have to tell him?
u')	62_13	D	Um, I really- we don't have enough information to know.

An initial departure from van Leeuwen is the addition of "impassive" to the choice between subjected and beneficialised to account for instances, including v') and x') below, which do not emphasise subjection or beneficialisation. In some cases they clearly contrast with more subjecting representations, as w') and y') show.

v')	45_83_2	P	and I was on ddC and AZT for oh about 2 weeks.
w')	(interpolated)		and you had me on ddC and AZT for about 2 weeks
x')	3_87_	P	so I'm on your cut off.
y')	3_82, 83	D	Yeah well ten thousand is my cut off. If we can get it within the ten thousand

Most instances of the category *impassive* are realized through circumstantiation:

z')62_13 D Yes, just stay on the drugs. Um, I really- we don't have enough information to know

Another departure from van Leeuwen's (1996) network as that choices about whether a social actor is activated or passivated is given here as potentially describable even if the social actor in question is backgrounded, or suppressed, whereas van Leeuwen requires that the social actor be fully textualised (what van Leeuwen calls Included) before anything can be said about their activation. Since these cases require illustration from longer stretches of text, examples will be cited below within extended text analyses.

6.3 Realms of action: material and semiotic

Although the depiction of social actors as material agents has turned out to be crucial to the depiction of their participation and centrality in other social processes (Trew 1979, Fairclough 1989), the construal of patients as material agents in medical decision-making does not seem to have the semantic effect of increasing their centrality as social actors. Being construed as agent in a material process may be more empowering than being construed as the passive goal of the actions of doctors, as portrayed in Sylvia Plath's classic fictional account, but in the present data such construals are rare, and the variable distribution of transitivity roles within a material paradigm accounts for very little of the marked sense of agency that does obtain in the consultations observed in this study. It is therefore important to examine how social actors are represented (textualised or not, agentive or passive, etc., as described above) against a background of how the activity being undertaken, or being projected, is itself construed by the doctors and patients.

In the context of HIV decision-making, and in discussions about decision-making styles more generally, it is important to understand the extent to which patients are construed as involved in deciding, choosing, discussing, informing, deliberating, knowing, interpreting etc., on the one hand, and in processes such as going to the pharmacist, taking pills, skipping doses, eating, etc., on the other, as

well as how agentively they are depicted with respect to such processes. In order to pursue how these issues are textualised, I make a primary distinction between types of action in terms of a revised interpretation of the semantic category of Figure (Halliday and Matthiessen 1999), as introduced in Chapter 4. The HIV decision-making data suggest that a primary distinction between types of activity/action[1] is required as follows. Semiotic Action is classified into Mental and Verbal action at the next level of delicacy.

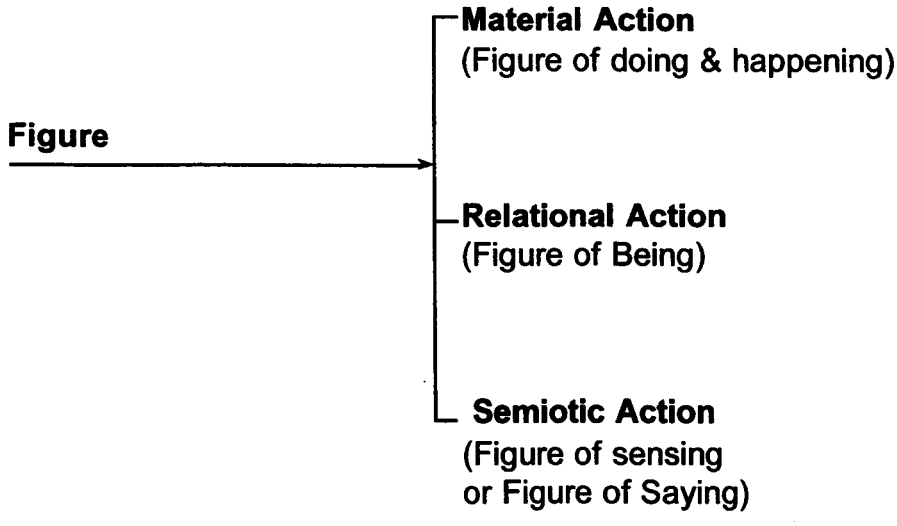

Figure 6.9 Network fragment for Figure type

As van Leeuwen argues, such choices of discursive representation of action are not determined by categories of "real life" activity but are resources for construing real life activities: "social action can be interpreted as material or semiotic, as 'doing' or as 'meaning'" (cf. Halliday 1984). Van Leeuwen glosses this distinction again as "action which has, at least potentially, a material purpose or

[1] For the purpose of this chapter I will speak of social action and activity as broadly synonymous, and will not maintain a distinction on the basis of agency (cf. Giddens 1984) or on the basis of rank/strata (contra Activity Theory), since to do so begs the question of how phenomena are represented linguistically from instance to instance, register to register and so on ... which is my main question.

effect", compared with "action which does not". Thus van Leeuwen's distinction runs according to the purpose or effect of the action. An alternative view is to consider the mode of the action. On such a view, material action would be interpreted as action which makes its impact via a material mode, whereas semiotic action would be action which makes its impact one some other entity via a semiotic mode. What appears to be the case based on the present corpus is that both distinctions – effect and mode – operate (cf. Talmy 1976, Croft 1991, cited in Palmer 1994: 29), although with different probabilities. For instance, prescribing a treatment can be "semioticised" (cf. van Leeuwen 1995), as in a") below, where "prescribing/treating" is represented as enacting a proposal, more particularly a command. Or it can be "materialised" as in examples b") and c"), where it is represented as "giving the patient" a particular drug or "putting the patient on" a particular drug.

a") 58_384_3 D In the past, what would happen is I would say, okay, could you please take this pill?
b") 59_275_2 D No, I'll give you this one here, Indinavir,
c") 37_52_2 P Yes, but why did they put you on Bactrim?

In addition, modes of semiotic action which realize propositions, as well as proposals, may be *materialised*, as in d") below which draws on the material grammar's resources for construing agency (putting/placing), and attributes this agency to the knower.

d") 59_58,60 D So you're at the top end of the moderate. Which is exactly where I would have put you. [1]

If we accept this primary distinction in terms of types of *action*, then we might expect that the semantics construes different types of *agent*, and may represent them in different ways. For instance, in the example above from Consultation 58 ("In the

[1] Note that the construction "I'd put you at X" is a particularly indeterminate construction, since it also construes an effective relational process in which the doctor is the Agent/Attributor.

past, what would happen is I would say, okay, could you please take this pill?"), we might initially argue that the doctor represents the patient as the agent, since it is the patient who is given the grammatical role of Agent as the taker of the pill. But it would not be satisfactory to leave the analysis there. We might additionally argue that the doctor is representing himself as a semiotic agent, as an entity which makes an impact on the patient through the semiotic mode, which in turn instigates an impact that the patient makes on himself or herself through the material act of taking the medicine. But there are a number of issues that need to be addressed in order to present the case that this small example instantiates a particular option from the meaning potential for construing agency in English. In what follows next I will briefly address the linguistic validity and motivation for this claim, before turning to demonstrate how such options chosen can be crucial in opening up or closing down the opportunity for joint decision-making about HIV treatment.

6.3.1 Strands of meaning across the metafunctions

The SFL model of language posits three distinct metafunctions that motivate and organise language as system and as instance. These metafunctions are best seen as "perspectives on meaning" (Halliday and Matthiessen 1999). There are crucial ways in which a particular strand of meaning may fragment across experiential, interpersonal and textual grammatical systems but still stay connected as one strand or thread at higher orders of abstraction[1]. The potential for interpersonal resources of Mood and Modality to provide strands of meaning that have experiential, or representational, value can be illustrated by tracking agnate constructions. Also illustrated in the examples below is the potential for agency to be construed as semiotic, or as material, or as some kind of influence that is left unspecified. Each

[1] I am not referring to grammatical metaphor here, which is a theory of alternative realizations of near-equivalent semantic structures. (E.g., "I think I'm going on Tuesday" is taken as another way of saying "I'm probably going on Tuesday".) I am referring to the way in which semantic categories such as agency "cross the floor" so to speak from the experiential grammar to the interpersonal grammar when semantic structures change. In addition, while there is a strong tradition in SFL of identifying the interpersonal value of experientially oriented functions, such as the cashing out of mental projection as Modality, it is less common to speak of the experiential value of interpersonally oriented functions.

construction represents the patient as agent of the process of taking pills. Simultaneously, each construction represents the doctor in some kind of second-order agentive role.

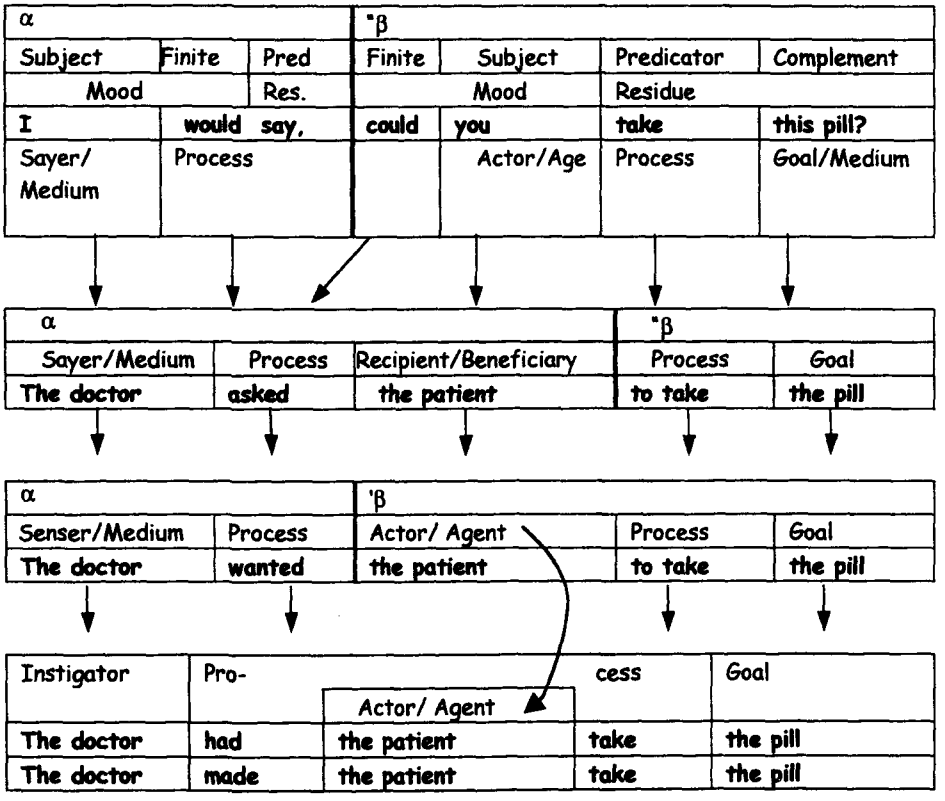

Figure 6.10 Projecting Agent relative to Instigator and Agent

The relevance of this illustration to the description of decision-making practice in HIV and more generally is this: as the dialogic interaction between doctors and patients moves between interpreting/negotiating test results and the patient's experiences, through to the hypothetical proposal of various options and deliberation about these, through to enunciative statements about what plan is to be agreed upon, and at some stage to procedural talk about when and how to take the pills, the

Agentive Role[1] of each party will be mapped in various ways into the texture of talk that constructs and enacts the decision-making options. But these changes in the context of talk will introduce some constraints on the way in which Agentive Roles are construed. We need a way of tracking logogenetically the ways in which the Agentive Role of the patient, for instance, is continually being nudged towards equality with the doctor, or towards a differentiated reciprocality, or nudged entirely out of any picture of agency. We need to be able to describe this logogenetic unfolding in terms that provide for potential equivalence between different phases of the consultation (although such equivalence may not be desirable). But we also need different "semantic phases" in a less temporal sense. For instance, we need to be able to account for the extent to which recontextualising someone's speech through reporting it maintains the agentive roles depicted in the previous version, or in any number of "versions" that may or may not ever be uttered (Bakhtin 1986, Baynham and Slembrouck 1999). But in order to do this sensitively we need to consider the extent to which recontextualisation *can* maintain the "same" agentive roles, given that different semiotic resources are required to produce this recontextualisation; and, if this is possible, which resources are used to do it. It is from this perspective that the notion of semiotic agent in treatment decision-making discussions becomes important.

6.3.2 Semiotic action: figures of Saying and Sensing

My network maintains two types of semiotic action: Mental (sensing) and Verbal (saying), as well as semiotic action that remains undifferentiated. This part of the network responds to a number of well-established arguments about the relation between discourse and action, which vary in substantial ways but can be summed up as the argument that discourse is itself a form of action and mediates almost all other types of action (Malinowski 1923, Austin 1962, Vygotsky 1978, Bakhtin 1986, Bourdieu 1991, Wertsch 1998). The point of this part of the network is to set out the meaning potential English offers for representing social actors (and inanimate actors)

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[1] Agentive Role here refers to the contextual parameter: see Chapter 5.

actors) as having semiotic agency – i.e., to show how speakers manipulate and repattern a grammar that seems designed to inscribe material agency, in order to represent semiotic action as having effects on the world outside of itself. The network should be able to distinguish ways in which language represents social actors as achieving or inducing effects on other entities in the world, through semiotic action of a verbal kind (e.g., *telling someone to do something*) and of a mental kind (e.g., *convincing someone of something*), as well as through more abstract action that can be seen as a verbal equation (e.g., *the point of this is that*).

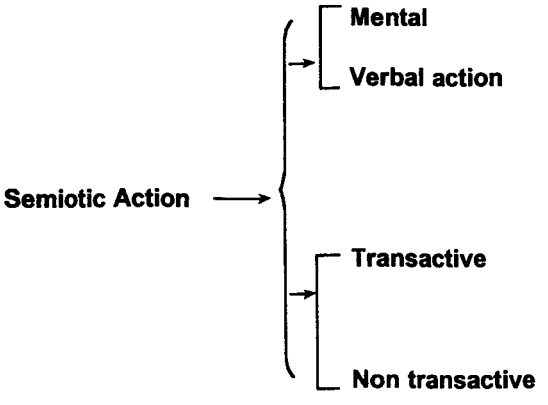

Figure 6.11 Network fragment following choice of Semiotic Action

For Semiotic action, there are a number of ways that the representation of a social actor's agency is foregrounded, contrasted, and manipulated – either to assert agency or to deny it. Both mental and verbal action vary by whether the action is transactional or not (after van Leeuwen 1995), where non-transactional includes, for example, "she talked about viral load for 20 minutes", " she remembered to take her pills"; while transactional includes "she talked to 20 doctors about viral load", "you have to remind yourself to take your pills". Since this network represents contrasts at the semantic level, an expression such as "we discussed the matter for 20 minutes" belongs in the transactional category with "she spoke to 20 members", not with "she spoke for 20 minutes" – it is not just a matter of whether there is one conscious grammatical participant or two.

Combining this with earlier distinctions we can distinguish, within the realm of semiotic action, between the following:

e") an *activated* social actor who is *self-activating* in a *transactional* action which is to influence one's memory

You have to remind yourself to take your pills

f") an *activated* social actor who is *other-activating* in the same *transactional* action of influencing someone's memory

he reminds me to take my pills

g") an *activated* actor who *self-activated* in a non-transactional action: the remembering is construed as just happening by itself

I usually remember to take my pills

h") and a *passivated*, *impassive* actor: remembering is construed not as a process or behaviour but as a near permanent attribute of the social actor.

I'm forgetful, yeah.

In addition, the directionality of transactional processes construes agency, as seen in the distinction between "He reminds me to take my pills" and "I remind him to get my pills".

Although it is possible to classify most instances as either verbal or mental, it is important to recognise the overlap between these two types of action from the point of view of agency. For instance, in the following example i"), the mode of action is verbal (*say*) but the realm of the effect is mental (*remind*). This is brought out also in example j"), in which an idea is projected three times – as the locution of the doctor, as the perception of the patient, and as the knowledge of the patient. Here the agency of the doctor's telling is emphasised, as it is the doctor's telling which is presented as causing the patient's realising/knowing.

i'') 59_631 D and if he really cares a lot about you, he's going to be wanting to say to you, "have you taken your pills?"

j'') 58_86 D Did I- did I tell you, ||did you realise, ||did you know, that you had campula bacta?

For Verbal action, when the action is *directional*, *transactional*, and construed as directed at a human or conscious social actor, a further choice applies, between *indicating* and *imperating* verbal action (examples k" and l" respectively)[1]. That is, as we saw above, agency may be fairly directly encoded in speech representation.

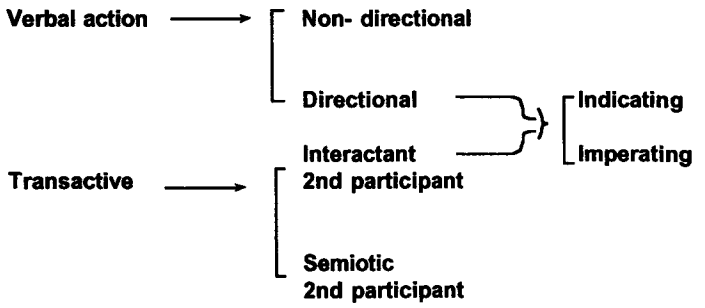

Figure 6.12 Further network fragment following choice of Semiotic Action

k'') 59_309_3 D A lot of Australians would - a lot of Australian doctors - say ||go for broke.
l'') 59_309_4 D And if you ask them ||what would you do ||if you had it, ||they'd say ||I'd take all four.

Both types of construal may of course be taken as advice (cf. Candlin and Lucas 1986), and it is interesting that doctors in the present sample engage with the question of what doctors would do themselves, since this tends to be a dispreferred response or even topic according to other studies.

Note how the presentation of the treatment options above emphasises the negotiability and perspectival nature of the options. In large part this is achieved by representing the argument as interactive, as individuals or groups of social actors talking to each other about their views. This in turn is largely achieved through the grammar of projection and verbal action.

As well as commands, *imperating* may convey offers, as in m") below.

m'')59_131 D It promises ||to make a gigantic difference to your CD4 count and to your viral load. But doesn't promise ||to get rid of your virus.

[1] Note that in a few cases mental action may also be imperating, as in "She needed him to go".

Here the Sayer that makes the promise is an inanimate object – antiviral treatment or a regimen of treatment – and in this regard there is a sense of undirected semiotic action: the promise is not made to any particular person. There is agency conferred to the treatment in the projected clauses (making a difference to CD4s, and getting rid of virus). However, if there is any contract between two parties construed in this utterance it would be between the speaker and the addressee, as conscious beings who can enter into agreements.

In instances where a human Receiver is either *visible* or *backgrounded* a clearer relationship of directionality between transacting parties is set up. For instance we interpret n'') and o'') below as conferring some sense of agency onto the party who asks another to act, as an indirect way of effecting action.

n'') 7_139P	P	I've asked him ||to increase the Eplim
o'') 37_242	D	Michael has asked (me?) || to postpone this for a two week period

In other instances, a directionality may be set up, in order only to use it to establish reciprocality, as in p'') below.

p'') 59_3	D	Well, how about you tell me about your reading first, ||then I'll discuss it- ||then I'll discuss my reading with you.

6.3.3 Types of mental action

It is also important to consider other salient distinctions maintained with relation to the type of semiotic agency construed. In particular, the literature on models of decision-making in medicine has defined and compared styles in terms of a primary distinction between "information" and "preference", and by the degree to which doctors and patients have responsibility, rights and roles in regard to these. Patients' roles tend to be associated with establishing and expressing subjective preference, whereas doctors roles tend to be associated with establishing and conveying objective information. The semantic contrasts between grammatically distinguishable subtypes of mental processing, namely Figures of *thinking*, *seeing*, *wanting*, and *feeling* as (Halliday and Matthiessen 1999), provide a useful way of exploring this area (these are also known as *cognitive*, *perceptive*, *desiderative* and *emotive*

subtypes respectively – see Halliday 1994, Matthiessen 1995, van Leeuwen 1995). The semantics of "preference" is likely to be realized through Figures of wanting and feeling, whereas "information" is likely to call on linguistic resources organised for construing cognitive and perceptive processing, but institutionally significant variation occurs which problematises the distinction between information and preference, and its association with participation role, as demonstrated below.

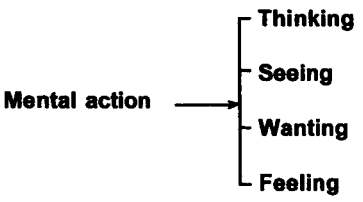

Figure 6.13 Network fragment for types of mental action

Examination of consultation data shows that the semantics of preference is woven through the semantics of institutional authority, and that HIV doctors routinely perform clinical recommendations as *desiderative* action: *prefer, rather, like*, etc. In particular, formal and informal statements about equipoise are typically realized linguistically through the semantics of the doctor's *emotion*: what they would *be happy with,* or what they would *be comfortable with.*

q'') 2_69_3 D All right then Phil ultimately if it's less than ten ||I'm going to be .. happy.

r'') 58_652 D If you find- if you find him- that works together, || I'm happy.

On the one hand representing recommendations in this way downplays their agency, since the grammar of English construes emotion and desire as non-volitional (cf. Matthiessen 1995, van Leeuwen 1995); but this can work to close down the negotiability of perspective and control. In example q") the doctor is making a statement about his policy with respect to evaluating treatment effectiveness. Being happy here equates with deciding to continue with the present treatment. Being unhappy equates with pressing for a change of treatment. Although this may seem

unproblematic, misalignment can be obscured by such semantic strategies for negotiating clinical contingencies. In example r") the doctor and patient have been discussing a complementary therapist that the patient attends, and the doctor wants to make sure that the complementary therapist will not talk the patient out of the antiviral treatments she is trying to persuade this patient to initiate. Here being happy for the doctor is less metaphorical, since the doctor's locus of control does not extend to the advice of the complementary therapist, or to the patient's choice to attend the complementary therapist, in the same way that the doctor in example q") could, in extremis, refuse to prescribe certain treatments to his patient.

A third and more metaphorical way in which the semantics of emotion is typically used in medical decision-making is seen in example s").

s'') 52_64 D And Brian Murray is very happy ||that she's not infected.

Here an HIV patient discusses with her doctor the HIV status of her infant daughter. The patient confirms the good news that her baby does not appear to be infected, appealing to the authority of her paediatricians for the claim: "They said it's basically nothing to worry about". The doctor responds with a report that a prominent consultant is happy that she's not infected. Is this a confirmation of empathy, along the lines of "Brian Murray wanted me to tell you he is so happy for you..."? There may be elements of this, but the main function of this comment is arguably to add evidence that the child is indeed not going to have HIV disease, by appealing to a particularly weighty authority. We can see this from the relevant polarity contrasts. "Brian Murray is not happy that she's not infected" would indicate not that he is displeased because someone does not have HIV, but that he is not convinced/satisfied/certain that the person does not have HIV. This evidence indicates that the process of being happy is projecting an idea rather than a fact (Matthiessen 1995: 260-262, Quirk et al. 1985: 1181). While in itself this kind of construction appears to be nothing more an "ordinary conversation" strategy used perhaps a little more frequently in medical discourse, from the point of view of the relationship between meaning potential and its realizational resources it may be problematic. The grammar of happiness is being forced to do triple duty in order to convey semiotic processes of suggesting and recommending, and to convey modality

(certainty/probability), and to convey states of emotion. This may make it difficult for patients to distinguish and disentangle personal and institutional aspects of doctors' perspectives.

6.3.4 Representation and phase

Finally, it necessary to observe the above dimensions and the degree and type of agency with which each participant is depicted according to the *phase* of the consultation in which it occurs. (These phases were described in Chapter 5.) An integrated version of the whole network appears on the following page.

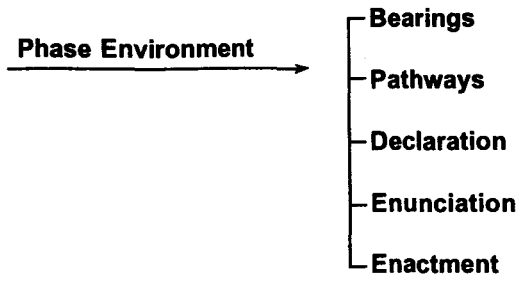

Figure 6.14 Phases of treatment decision-making in HIV medicine

6.4 Treatment initiation, agency and identity

Having introduced the above dimensions of agency and their interactions, I am now in a position to discuss the complex negotiation of agency in HIV decision-making consultations, beginning with consultations that raise the issue of initiating treatment with combination therapy (HAART).

6.4.1 Sharing the decision to initiate treatment - Karen and Joan

The issue of starting treatment is discussed over two consultations, 58 and 59, by doctor Karen and patient Joan. By the end of Consultation 58 Joan has agreed to initiate therapy, and Consultation 59 is a follow-up consultation in which they resolve the issue of whether to take dual therapy or triple therapy, and which drugs in particular. In the time between these consultations, Karen and Joan have both read the same material on indications for treatment and treatment choices. Each consultation is long (approximately 1 hour each, with approximately 1400 and 2000 clauses respectively). At that length, it is impossible to show whole texts here, so I will use key selections to illustrate some of the typical features that build up the discourse environment of these consultations, as well as tracking the logogenetic movement through the phases of the decision. These features contribute to a type of shared decision-making which can be described as doctor scaffolded but patient focussed[1].

I will begin with a short extract from Consultation 58. The column marked "semiotic agent" in this table and subsequent tables summarises key aspects of the representational practices used, in terms of whether semiotic agency is construed and, if so, which social actor or other entity is positioned as semiotic agent. These codings are drawn on in the discussion to track interdependencies and shifts in agency as the consultation unfolds. The most important interdependency here is the semantic dependency created by projection and quasi-projection. Thus the code D"P, for example, shows where the doctor projects the patient's view.

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[1] This style of decision-making is not unlike Linell et al's description of partnered care as a "collaborative communicative project" led by a doctor or other health professional (Linell et al. 2002: 215-6).

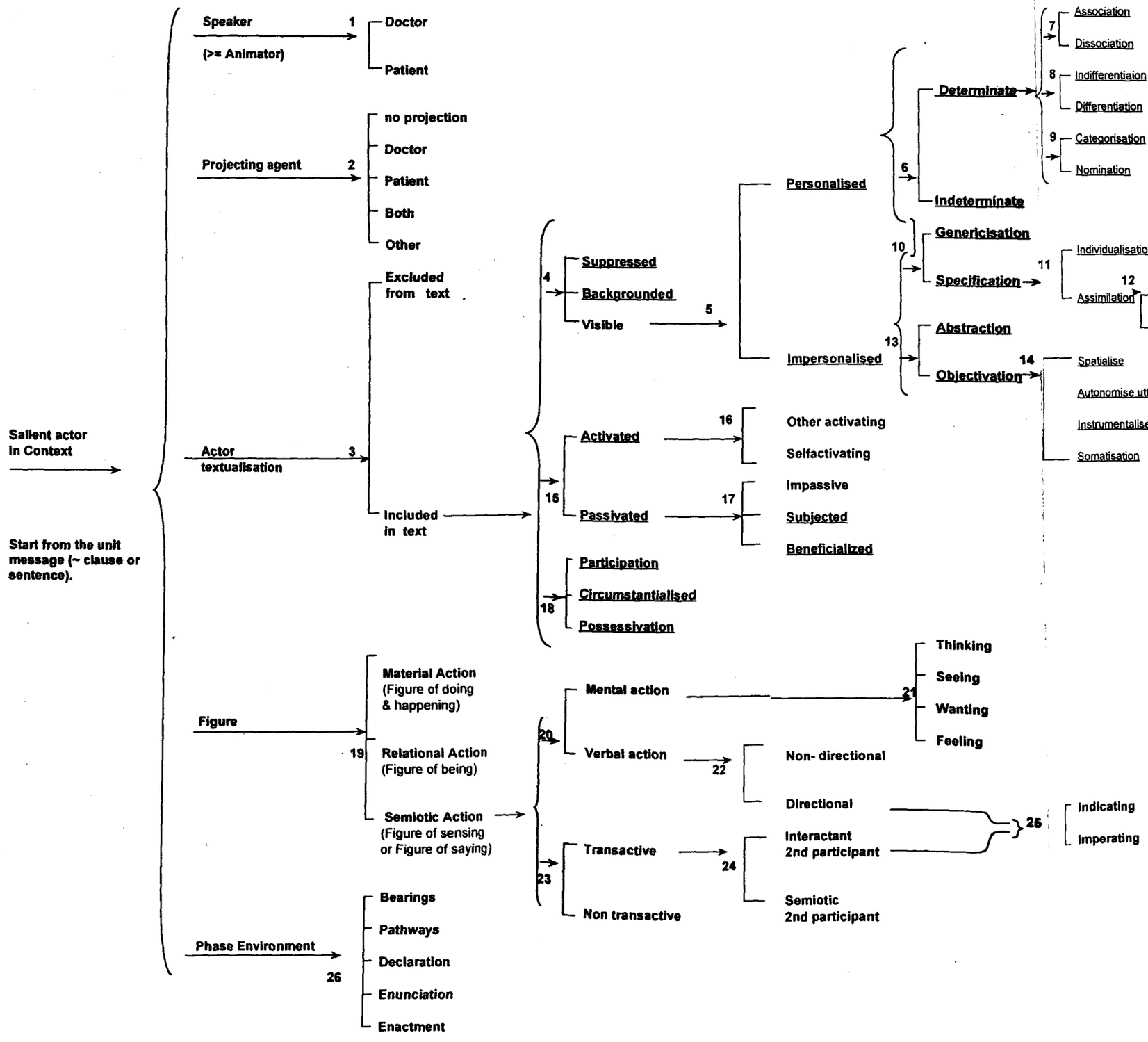

Figure 6.15 Participant agentivity network for decision-making in HIV medicine (adapted from van Leeuwen 1995, 1996; see also Butt and Moore (2002)

Viral load: story and message

Table 6.1 Extract 1 from Consultation 58: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: Propose agenda	58_264_1_1	D	Okay, we were gonna talk about your viral load story.	D+P
	58_265_1_1	P	Okay.	
PROPOSE: declare	58_266_1_1	D	Now the back- the end of the story message is, [[you- it's time you went on treatment]]	story
AMPLIFY	58_266_2_1	D	And I'm sorry [[to start that way]],	D
	58_266_2_3	D	but I think I have to start that way	D'D
	58_266_2_4	D	so you know	P'D
	58_266_2_5	D	where I'm going be going to.	
	58_267_1_1	P	Okay	
	58_268_1_1	D	All right?	
	58_268_2_1	D	And I'll show you why.	D

This decision-making episode begins with an abstract of the doctor's argument. The discussion begins with the doctor representing herself and the patient as *collective, undifferentiated verbal agents* at turn 264, but shifts quickly into *differentiating* herself as the initiating semiotic agent, in the sense that she will lead the patient through an already shaped "viral load story", where the patient is the *passivated receiver* and *beneficiary* of the story's message. The story itself is represented as the *projecting, imperating agent* of this message which ultimately effects the patient's physical change in state, from not on treatment to taking treatment. But within this representation of the agency of the doctor and the story, the patient is represented as having the capacity for and the right to semiotic agency, not merely the responsibility for the material agency of taking pills. This can be seen in clauses 266_2_3 to 266-2-5, where the doctor identifies the patient's knowledge of the doctor's view as her explicit goal; and again in 268_2_1, where she identifies displaying her own evidential framework as a related goal.

From the outset, then, despite the monologic interactional structure, the patient's role as a semiotic agent is promoted by the representational structure (or experiential

meaning) of the discussion. This also establishes the creation of a shared view as both goal and topic of discourse (cf. Sarangi and Coulthard 2000), and establishes the context about to unfold as: likely to be specialised, and reflective, in terms of Field; likely to involve complementary and agentive roles, with relatively weak framing, in terms of Tenor; and where the role of language will be constitutive (Hasan 1999, Butt 2000b), along with other and more delicate contextual features, as discussed in chapter 5.

In turns 269 to 468, which are omitted here but shown in Appendix 1, Joan and Karen range over topics such as how to interpret viral load, the difference between viral load measurement and other markers such as T cells and antigen tests, the different philosophies of different speakers at a recent conference, the 'irony' of recreational drug users refusing to take antiviral treatments because "their body is a temple" and many others. The patient entertains the idea of treatment and challenges and seeks elaboration of the doctor's arguments but then expresses her complacency about the issue. At this point the doctor moves into an even more persuasive mode, which we pick up in the next extract.

Projecting future selves: to float or to push?

Table 6.2 Extract 2 from Consultation 58: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: values calibration	58_469_1_1	D	There are two things [[that I think ||you have to think about]].	D!P'P
	58_469_2_1	D	Okay?	
	58_469_3_1	D	First thing is [[you actually have to get it into your head || that this makes YEARS of difference to your life]]	
	58_470_1_1	P	Mm-hmm.	
	58_471_1_1	D	Years of difference.	
	58_471_3_1	D	Number two is,	
	58_471_3_2	D	[[you've got to get serious about yourself]].	
	58_471_4_1	D	You tend to swan around.	
	58_471_5_1	D	Y'know you tend to sort of just float around in your life,	
	58_472_1_1	P	Mm].	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	58_473_1_1	D	But, you've got the brains and the ability and even the- the power, the physical strength, [[to actually push yourself into this]]	
	58_473_1_3	D	and actually make things [[of what you're doing]].	
	58_474_1_1	P	Mm-hmm.	
	58_475_1_1	D	This can give you that resource.	treatment?
	58_476_1_1	P	Mm-hmm	
	58_475_2_1	D	Yes, it makes you feel crappy to start with,	
	58_477_1_1	D	And taking pills is not wonderful.	
	58_477_2_1	D	The majority of people who - <<I can't say the majority>>-	
	58_477_2_2	D	we certainly know	D / D+ as institution
	58_477_2_3	D	that lots of people [[have been unwell related to their HIV]] certainly do so much better	
	58_477_2_4	D	when they're on the new combinations of pills.	
	58_478_1_1	P	Mm.	
	58_479_1_1	D	It really makes a difference.	
	58_480_1_1	P	Okay.	
	58_481_1_1	D	Now if you like-	
	58_481_1_2	D	you've already-	
	58_481_1_3	D	I don't know whether or not this CIN3-	
	58_482_1_1	P	What you said before is- you were saying.	D
	58_482_1_2	P	that I- I can get some potential back in my life, as well	
	58_483_1_1	D	That's right	
	58_484_1_1	P	You're not just saying	D"P'
	58_484_1_2	P	that if I believe in this	
	58_484_1_3	P	I can make myself well.	
	58_484_2_1	P	You mean	D' P '
	58_484_2_2	P	I can make myself well enough [[to .. BELIEVE in something else]],	
	58_484_2_3	P	which is where [[my problem is]].	
	58_485_1_1	D	That's it.	
	58_485_2_1	D	That's- that's- look, I- I- I have to tell you,	D
	58_485_2_2	D	sat there listening to these guys	
	58_485_2_3	D	and I- all I could think of was you.	
	58_485_3_1	D	I had Joan Bradley in my brain.	

In this extract, the representation of semiotic action dominates the text. At times, semiotic action is represented as jointly undertaken (turn 264). The doctor and patient tend to project each other's point of view, including each other's thoughts (clause 266_2_4, clause 484_1_1), sayings (clause 482_1_1), and commands (clause 469_1_1). As we will see below, semiotic agency may also be represented as reciprocated between doctor and patient as two separate, differentiated individuals.

In addition, semiotic objects themselves continue to be animated as symbol sources to various degrees, as we saw in the doctor's message at clause 58_266_1_1, in which the story is represented as telling the patient to go on treatment.

Where the doctor is *speaker*, in the above extract, the patient is the most prominent represented social actor, but the doctor presents two 'versions' of the patient's identity. In the first version the doctor represents the patient as currently *passivated*, by representing her as participating in *non-transactive* low-potency activities (turn 471, *You tend to sort of just float around in your life*). The patient's level of participation, as well as the negativity of this appraisal, is downgraded through modality, viz. "tend to", "just" and "sort of". The patient is also passivated through *circumstantialisation*– e.g., the *spatialisation* of "floating around in your life", which contrasts with controlling and effecting change in one's life. In the alternative version of the patient's identity offered by the doctor, the patient is highly *activated* with respect to directing her life. She is activated through *participation* as the *possessor* of a range of mental and physical resources which – along with the resource of treatment – give her the capacity for *self-activation* of a complex agency over her physical and mental life. This is well demonstrated in the doctor's utterance at turn 473:

58_473_1_1 D But, you've got the brains and the ability and even the- the power, the physical strength, [[to actually push yourself into this || and actually make things of [[what you're doing]]]].

Note that here and in other parts of this consultation the grammatically agentive structures are embedded and hence in a way circumstantialised as qualifiers of the strength the patient has. Arguably, this form of representation construes the capacity for action as a relatively permanent quality of the patient's character, rather than as a more temporary resource or focus. This seems to be consistent with a *personalised*, *individualised*, and highly *differentiated* representation of the patient, in which resources are to be found from within. This is still a complex conceptualisation of agency. Crucial here is the complex interrelation between material action and semiotic action, and between the doctor and the patient as the author, animator and

principal of the available and chosen views as the consultation progresses. A case in point is the way Joan, the patient, responds to Karen's contrast of agency with a contrast of her own, which she attributes back to Karen:

58_484_1_1 P You're not just saying
58_484_1_2 P that if I believe in this
58_484_1_3 P I can make myself well.
58_484_2_1 P You mean
58_484_2_2 P I can make myself well enough [[to .. BELIEVE in something else]],
58_484_2_3 P which is where [[my problem is]].

We can depict these two positions as shown in Figure 6.16 below. The contrast between position 1 and position 2 in the diagram below – in the patient's re-authoring of the doctor's view – is between the semiotic act of believing in treatment as a resource for material improvement in position 1, and physical improvement as a resource for believing in some better form of life in position 2. Figure 6.16 suggests that a model of agency in which semiotic and material modes of action mediate each other is not merely the preserve of academic social theorists, but relates to ways of describing the world that have relevance and currency within healthcare management. The question of how to think about the relationship between thought and action is relevant to the day-to-day business of the doctor and patient in consultation, articulated through the latent patterning of their discourse, even if it is not the subject of any metadiscourse.

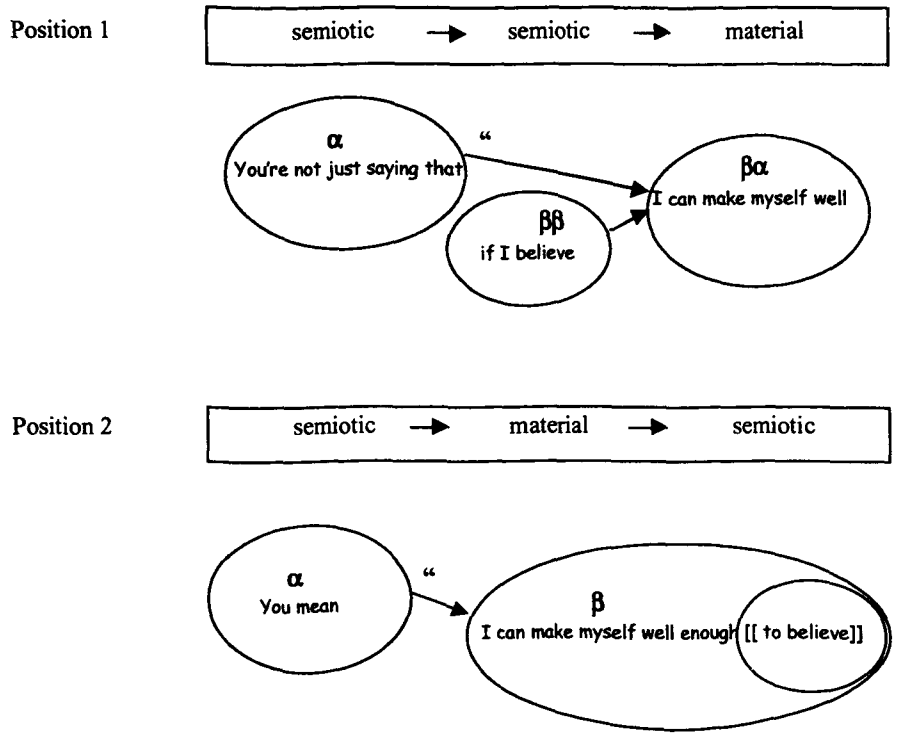

Figure 6.16 Relations Between Material and Semiotic Agency in Consultation 58

Identifying weight, viral load, and treatment options

Consultation 58 culminates in the patient agreeing that taking combination antiviral therapy (HAART) is a good idea, and agreeing to come back in a week to consider which treatments. When Karen and Joan meet again they begin with a focus on the physical – reviewing the patient's weight. The discussion then turns to selecting treatments, the pre-established main agenda. At first glance there is little cohesion between the two sections. However, as we shall see below, the discussion of the patient's weight is central to the narrowing of treatment choices into a particular decision. This is significant for the examination of agency in treatment decision-making, since it emphasises the point that systemic and instantial analytic perspectives are both required because generalised resources for construing agency,

such as those outlined in the network above, are deployed and combined in locally specific ways. In the case of Joan and Karen, one set of essentially *passivating* and *materialising* representational choices construes the patient's identity in terms of physical vulnerability and *permanent association/undifferentiation* with the virus. These interact with another set of essentially *activating* and *semioticising* choices which construe her as a capable, responsible, agentive self. A third strand relates to the doctor's interdependent agentive role. This complex representation of agency is closely tied to the way in which the specific treatment choice is made.

Table 6.3 Extract 1 from Consultation 59: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS	59_1_1_1	D	You were:	
	59_2_1_1	P	Well, I'm about- I should- sixty three.	(scales)
	59_2_2_1	P	Was this the last one?	
	59_3_1_1	D	Sixty-three point seven five in November.	
	59_3_2_1	D	You're now sixty-one.	
	59_4_1_1	P	Yeah.	
	59_4_2_1	P	So now I'm sixty-one.	
	59_4_3_1	P	That's how I feel too.	P
	59_5_1_1	D	Why've you lost weight?	
	59_6_1_1	P	So.	
	59_6_2_1	P	I've been really, really distracted and completely off food.	
	59_6_3_1	P	Like getting to a point where, you know, like I'm just about to faint from starvation	
	59_6_3_2	P	when I do something about it, you know?	
	59_6_4_1	P	But I've recognised it.	P
	59_7_1_1	D	Distracted by what?	Life
	59_8_1_1	P	Life.	
	59_9_1_1	D	Life, the universe and everything?	
	59_10_1_1	P	It's really unlike me.	
	59_10_2_1	P	Yeah.	
	59_11_1_1	D	That's surprising.	
	59_11_2_1	D	I quite agree with you.	D
	59_12_1_1	P	Usually I'm quite obsessed with food.	food
	59_12_2_1	P	I'm- hmm?	
	59_13_1_1	D	T- y- be distracted.	
	59_13_2_1	D	Y- I've never known [[you being distracted]].	D
	59_14_1_1	P	It's good.	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_14_2_1	P	Yeah, it is good, from food anyway.	
	59_14_3_1	P	I'm- but I- y'know, I need to- I've got myself sorted out.	P
	59_14_4_1	P	I've got a little esky in the car,	
	59_14_4_2	P	and I've got some Iku casseroles and some um other things	
	59_15_1_1	D	Excellent	
	59_17_1_1	D	Excellent	
	59_18_1_1	P	So I'm going to bung 'em in the freezer	
	59_18_1_2	P	so, that my y'know, so that they're there.	
	59_18_2_1	P	Cos that's the problem,	
	59_18_2_2	P	I don't know [[what I want to eat†]],	P
	59_18_2_3	P	and I just- not until someone- not until I get the smell	smell
	59_18_2_4	P	do I- y'know	
	59_18_2_5	P	and then I start [going hhhhhh ((inhales strongly)).	
	59_19_1_1	D	And Iku food is v-] it's great.	
	59_19_2_1	D	Because it'[s- it's light	
	59_20_1_1	P	Yeah, it is.]	
	59_21_1_1	D	and it's pleasant and it's ..	
	59_22_1_1	P	And it's got some legumes	
	59_22_1_2	P	and that's [[what I don't like to cook myself]].	
	59_23_1_1	D	all those important thingummy whats.	
	59_24_1_1	P	Yeah.	
	59_24_2_1	P	So I got some of those today	
	59_24_2_2	P	and thought, yeah-	
	59_25_1_1	D	Should buy them cooked and canned.	
	59_26_1_1	P	And my friends are all out happening, y'know,	
	59_26_1_2	P	feeding me on Tuesdays and Thursdays and ((laughs))	
	59_26_2_1	P	It's all right	
	59_27_1_1	D	Oh well, that's good.	
	59_28_1_1	P	Yeah	
BEARINGS: Propose agenda	59_29_1_1	D	All right.	
	59_29_2_1	D	Now what [[we've come here	P+D
	59_29_2_2	D	to discuss today ..]]	
	59_30_1_1	P	Yes, I've done my reading.	P
	59_30_2_1	P	Yeah, what- what is it [[that you wanted to discuss with me]]?	D+ P
	59_33_1_1	D	Well, how about you tell me about your reading first,	P
	59_33_1_2	D	then I'll discuss it-	D
	59_33_1_3	D	then I'll discuss my reading with you.	
	59_34_1_1	P	Okay.	
	59_34_2_1	P	I read- I read ah this,	P

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_34_2_2	P	and ah - have you got that?=	
	59_35_1_1	D	Hold on, which one have you got?	
	59_36_1_1	P	And I read this.	P
	59_36_2_1	P	Have you got that?	
	59_37_1_1	D	Yeah.	
	59_37_2_1	D	I was just about to- .. snap!	
	59_38_1_1	P	Brand sparkling new.	
	59_39_1_1	D	Look!	
	59_40_1_1	P	Okay.	
	59_40_2_1	P	I've got that as well.	
	59_40_3_1	P	All right, so we both read that.	P+D
	59_40_4_1	P	Okay umm, this made me feel	book' P ' P+D
	59_40_4_2	P	like, umm, our decision [[to go on treatment]] is a good idea.	
	59_40_5_1	P	Okay.	
	59_41_1_1	D	Yeah.	
	59_42_1_1	P	So that's- that's from [[reading this and understanding this]].	Reading
BEARINGS: MARKERS: offer/ demand results	59_42_2_1	P	I don't know what my viral load is though.	P
MARKERS: offer/ demand results	59_42_3_1	P	What is it?	
MARKERS: deliver results	59_43_1_1	D	I can tell it to you.	D
	59_43_2_1	D	Are you ready for this?	
	59_44_1_1	P	Yep.	
	59_45_1_1	D	Your viral load is...	
	59_45_2_1	D	That's interesting.	
	59_45_4_1	D	Hang on, I'll get give it to you.	
	59_45_5_1	D	I've got it.	
	59_46_1_1	P	Yeah, I know.	
	59_48_1_1	D	I'll just take this outside.	
	59_48_2_1	D	Hang on.	
	59_48_3_1	D	Um, excuse me a second.	
[parallel	59_49_1_1	P	Yep.	
context/ text]	59_49_2_1	P	Should I just talk?	
	59_50_1_1	D	So you just talk to the tape, that's right!	
	59_50_2_1	D	Exactly	
	59_51_1_1	P	((I)) ... Sixty-one point three kilograms.	
MARKERS: deliver results	59_52_2_1	D	That looks like a viral load.	
	59_52_3_1	D	Four thou- forty-eight thousand six hundred and seventy two:	
MARKERS: evaluate results	59_53_1_1	P	God, that's pretty high, isn't it then.	
	59_54_1_1	D	Well,	
	59_55_1_1	P	Mm.	
	59_56_1_1	D	it's not.	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_56_2_1	D	It's sort of the mediumish kind of a range.	
	59_57_1_1	P	Says here	book
	59_57_1_2	P	ten to fifty thousand is moderate,	
	59_57_1_3	P	and fifty thousand is considered high.	
	59_58_1_1	D	Yeah.	
	59_58_2_1	D	Okay.	
	59_58_3_1	D	So you're- you're at the top end of the moderate.	
	59_59_1_1	P	Yeah, all right.	
AMPLIFY shared technical code	59_60_1_1	D	Which is exactly where [[I would have put you]].	D
	59_60_2_1	D	[[Our- the sort of way [[that we run on this]] is, [[ ]]	D+ as institution
	59_60_2_2	D	[[if you got a rate of a hundred thousand,	
	59_60_2_3	D	I'm going to sit on your head	
	59_60_2_4	D	and make you take treatment, right?]]	
	59_61_1_1	P	Okay.	
	59_62_1_1	D	If you've got a rate of less than ten thousand,	
	59_62_1_2	D	I'm going to say,	
	59_62_1_3	D	it's a good idea,	
	59_62_1_4	D	but you think about it.	
	59_62_2_1	D	And between ten and a hundred, or maybe even fifty, y'know, or between ten and a hundred I'd say,	
	59_62_2_2	D	increasingly it's a good idea.	
	59_63_1_1	P	Okay.	
RECAP: recap decision/enactment plan	59_64_1_1	P	So that's probably what we did.	P+D
	59_65_1_1	D	And that's exactly what-	
	59_65_1_2	D	but that's what we've reached.	
	59_66_1_1	P	That's what we've done, yeah.	
	59_68_1_1	P	Yep.	
	59_69_1_1	D	So.	
	59_69_2_1	D	You know	
	59_69_2_2	D	that's not so stupid.	
	59_70_1_1	P	No, that's fine.	
	59_71_1_1	D	Right?	
	59_71_2_1	D	So that sort of time scale and all the rest of it is actually quite reasonable.	
	59_72_1_1	P	Mm-hmm	
	59_73_1_1	D	Okay?	
	59_74_1_1	P	Okay.	

In turns 1 to 28, during the reporting of the patient's weight loss, the patient is constructed as an *impassive, non-volitional senser* in the process of feeling a certain

way about her body. Life is *activated* as the phenomenon producing in Joan the mental state of distraction, and this is contrasted with her normal state in which food is the active agent of a mental state of obsession. The smell of food is still agentive in bringing about the patient's desire to eat. However, interwoven with this passivated depiction, the patient is represented (by herself) as the somewhat less *passivated* senser in the process of recognising some of the dangers that being distracted entails, and she projects one token of self-activating action in turn 14, of needing to/having got herself "sorted out" (the finite operator switches within the message).

There follows a context-shifting move, which acts as the proposal of an agenda with regard to discussing antiviral treatment (*"All right. Now, what we've come here to discuss today..."*). In this phase, in which they go through the reading that each has done, the patient and the doctor are mostly represented by each as *personalised, activated semiotic* agents who engage in *indicating, verbal* action, where that action is either *non-directed* or *directed* but reciprocally so (e.g., turn 33, you tell me about your reading, then I'll discuss my reading with you). In addition, they represent each other as undifferentiated (joint) agent at clause 29_2_1, 230_2_1, and 40_3_1. Such representation contributes to the sense of complementary agentive roles, and the sense of close scrutiny of each other's views, evidence and sources of evidence. The book and the process of reading come into play in this section as agents of the patient's positive feeling about and appraisal of the as-yet-irrealis decision to treat.

The patient's move at clause 42_2_1 brings the focus to the here and now of her particular viral load measurement, realizing the contextual moves of *demanding* and *delivering result*s. As part of accomplishing this contextual move the doctor *activates* herself as the semiotic agent of a *transactive, directed semiotic process*, and *passivates* the patient by beneficialising her role in the assessment of markers (turn 43, 45) or by construing the patient as a level of virus, assignable through circumstantialisation to one of a set of risk categories (turn 60). The book on treatments, and the institution of medicine more generally, get textualised here, somewhat covertly, as agents of treatment policy, especially at turn 57 (*Says here, ten to fifty thousand is moderate and fifty thousand is considered high*). Note that this policy is impersonalised utterance autonomisation, and represented as a verbal equation:

viral load x = risk category z.

In turn 60, the doctor recontextualises this policy, re-activates its representation into the cause-and-effect of action, and re-animates the agency of the institution and its representatives. Thus the impersonal becomes personal:

if viral load is x, then I will do/say z.

It is the patient, though, who represents the policy just articulated by the doctor as equivalent to what they have just done, as undifferentiated social actors, which indicates a high level of agreement between the doctor and the patient about the relationship between options in the treatment policy, as system, and the choice they have made so far, as instance[1].

This observation is similar to the key point made by Adelswärd and Sachs (1998) that risk values are made meaningful for patients in terms of the actions they imply rather than the categories they instantiate. The data from Karen and Joan suggest the following additional observations. It seems to be valuable that such recontextualisations are done as a matter of course and as part of the evaluation and explanation of results, rather than leaving the implicational relationships between categorisation and action to be inferred by patients. It also seems highly valuable to re-animate and re-verbalise policies as the doctor does in Consultation 59, so that the doctor and patient are re-mapped into the policy as participants in verbal and material activities. This appears to encourage and facilitate patient participation in the clinical reasoning that follows. It is also worth noting that in the doctor's version of this policy the forcefulness of the doctor's response is shown as contingent on the severity of risk suggested by the viral load result. There is an implied grading of the doctor's agentivity from high risk, high agency, construed as material *subjection* of the patient (*I'll sit on your head || and make you take treatment*) to lower risk, and more shared, negotiated agency, construed by *activating* and *associated* but

[1] For reasons of space, it is possible to expand only briefly on the way in which viral load is itself multiply coded and must be considered according to the different discourses its discussion indexes, but see appendix 4, which reproduces a published paper on this subject, for which I was the principal author, with co-authors Professor C.N. Candlin and Dr G.A. Plum.

differentiating the doctor and the patient as *participants* in *verbal and mental activity* (*"I'd say || it's a good idea but you think about it"*).

Personalising treatment choice

After a detailed consideration of a range of different drugs available and other issues, the doctor uses a similar kind of recontextualisation strategy to summarise implicational dependency relations, this time between treatment choices and patient preferences. Note how the semiotic agency analysis suggests complex mutual projection of what each other has thought or said, or might say or think.

Table 6.4 Extract 2 from Consultation 59: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: declare rec &evaluate alternatives	59_117_1_1	D	What I think you should start on in it- now, <<	D
	59_117_1_2	D	do you remember the conversation we had last time,	P" P+D
	59_117_1_3	D	when I said to you,	D' P"P
	59_117_1_4	D	you need to decide	
	59_117_1_5	D	whether you want	
	59_117_1_6	D	to get down to no viruses,	
	59_118_1_1	P	Mm-hmm.	
	59_119_1_1	D	or, whether you want to- << >>	
	59_119_1_2	D	<<which- which is hard to do in terms of medication	
	59_119_1_3	D	but .. some people would argue has the best options for your future life>>	some people
	59_120_1_1	P	Mm-hmm	
	59_121_1_1	D	versus, being able to live a reasonable life now,	
	59_121_1_2	D	and tolerating a little bit of virus.	P
	59_121_2_1	D	And it's up to you [[to tell me|| which of those two paths you want]]	P "
	59_122_1_1	P	Oh right.	
	59_122_2_1	P	Okay.	
	59_123_1_1	D	So.	
	59_123_2_1	D	And the reason [[that's important]]- cause it- [[that determines [[what you end up taking]]]].	reason
	59_123_3_1	D	And this is [[what I'm talking about]].	D

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_123_4_1	D	If you say to me,	
	59_123_4_2	D	I'd like to get down to um less than a thousand,	
	59_123_4_3	D	but I don't really mind	
	59_123_4_4	D	if I get down to zero,	
	59_123_4_5	D	then I will say to you,	
	59_123_4_6	D	take these two drugs, 3TC and AZT,	
	59_124_1_1	P	Mm-hmm.	P"P' -> D!
	59_125_1_1	D	okay, which are like double treatment,	
	59_125_1_2	D	and KEEP the protease inhibitors up your sleeve.	
	59_126_1_1	P	Mm-hmm.	
	59_127_1_1	D	In case you can't manage one of these,	
	59_127_1_2	D	or in case something happens	
	59_127_1_3	D	and you get sick	
	59_127_1_4	D	or there's some other option.	
	59_128_1_1	P	Mm-hmm.	
	59_130_1_1	P	All right.	
PROPOSE: describe treatments	59_131_1_1	D	It promises	treatment
	59_131_1_2	D	to make a gigantic difference to your CD4 count and to your viral load.	
	59_131_2_1	D	But doesn't promise	
	59_131_2_2	D	to get rid of your virus.	
	59_132_1_1	P	Okay.	
	59_133_1_1	D	Now, if you say to me,	P" P'
	59_133_1_2	D	no, no, no, I have come to the psychological time [[ ]]	
	59_133_1_3	D	[[where I want to be as virus-free as [[ ]]	
	59_133_1_4	D	[[you can make me]]]],	
	59_133_1_5	D	THEN we go ALL OUT for treatment.	
	59_133_2_1	D	And some people would even give you four things, not just three.=	some people
	59_134_1_1	P	Right	
	59_135_1_1	D	Three being AZT, 3TC and maybe saquinavir or maybe indinavir,	
	59_135_1_2	D	which is- there's a- you know there's a number of different proteases	
	59_136_1_1	P	Yeah.	
	59_137_1_1	D	and the which one [[you choose]] is kind of=	P
AMPLIFY	59_138_1_1	P	=I understand	P
	59_138_1_2	P	how they work,	P-> D
	59_138_1_3	P	but I don't understand	
	59_138_1_4	P	how the- w- these work.	
	59_138_2_1	P	Why is that?	
	59_138_3_1	P	Because I haven't read, or?	
	59_139_1_1	D	Oh, because they may assume-	book
	59_139_1_2	D	I don't know what-	
	59_139_1_3	D	I don't know	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_139_1_4	D	if it's in that book or not.	
	59_140_1_1	P	There's a whole little thing in here about how-	
	59_141_1_1	D	Yep.	
	59_141_2_1	D	Let's look at the h- let's look at this.	
	59_141_3_1	D	Let's look at this.	
132 turns omitted on mechanism of viral replication etc.				
PROPOSE: describe treatments & evaluate	59_273_2_1	D	This drug is very difficult to take, saquinavir,	
	59_273_2_2	D	because it interacts with lots of other things.	
	59_274_1_1	P	Mm.	
DECLARE: declare recommendation/pref	59_275_1_1	D	This one, ritonavir - am I getting it right?	
	59_275_2_1	D	No I'll (give you) this one here,	D
	59_275_2_2	D	indinavir, is really easy to take.	
	59_275_3_1	D	You take it	
	59_275_3_2	D	before you eat.	
DECLARE: values calibration:	59_276_1_1	P	You reckon	D
	59_276_1_2	P	that's easy!?	
	59_277_1_1	D	Right?	
	59_278_1_1	P	Look at that,	book/ product information
	59_278_1_2	P	avoid food one hour before and two hours after [[taking it]]?	
	59_278_2_1	P	Basically, if you were trying to do that,	D
	59_278_2_2	P	you'd never eat.	
	59_278_3_1	P	Don't you reckon?	
	59_279_1_1	D	((squeaky sound = maybe/maybe not))	
	59_280_1_1	P	This says	book!
	59_280_1_2	P	food one hour before.	
	59_280_2_1	P	Avoid food one hour before.	
	59_280_3_1	P	All right.	
	59_280_4_1	P	So if I had've eaten last night	
	59_280_4_2	P	and I was going to take it,	
	59_280_4_3	P	I would take it in the morning	
	59_280_4_4	P	and then .. two hours later I'd be able to have my breakfast?	
	59_281_1_1	D	That's right.	
DECLARE:	59_282_1_1	P	It'd never work.	
	59_283_1_1	D	Couldn't do it.	
	59_283_2_1	D	Couldn't do it.	
	59_283_3_1	D	All right.	
	59_283_4_1	D	Okay.	

As the discussion moves from the proposal phase towards the declaration phase, the patient's agency is highlighted. Despite the highly directive, persuasive style of the doctor, her suggestion as to which actual treatments she would recommend (turn 275) is rejected by the patient. At turns 276 and 278 the patient queries the basis for

the doctor's construal of indinavir as easy to take, inviting the doctor to hear her rationale, while making her argument more than a personal rejection by *genericising* the social actor involved in the projected act of eating, treating and organising treatment.

Declaring and enunciating the decision

Some 200 turns later the patient puts forward what might be a tentative decision, but which the doctor works into an explicitly enunciated decision, as shown below. Note that in displaying the rationale for her decision, Joan predominantly represents herself again as a relatively passive semiotic agent in the action of *feeling*, but also as a kind of interpreter of what her body is feeling, where Joan and her body are *differentiated*, and her body represented as an somewhat independent semiotic agent. In this section, when Joan represents herself as actively thinking, this tends to project constructions where some physical attribute or process (being bony, eating) is the focus.

Table 6.5 Extract 3 from Consultation 59: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: evaluate alternative strategies, motivate	59_449_1_1	D	The trick is [[to keep yourself at a nice healthy level]].	
	59_450_1_1	P	Mm-hmm.	
	59_451_1_1	D	So you can watch [[what's happening]].	
	59_451_3_1	D	And get in there.	
DECLARE: declare recommendation /pref	59_452_1_1	P	Well I think,	P'
	59_452_1_2	P	possibly we should start on these two	
	59_452_1_3	P	because the way [[my body feels]] at the moment is, [[I can't-]] just simple things.	P's body
	59_452_2_1	P	Like I went and had two cups of coffee the other night	
	59_452_2_2	P	and I FLEW off my BRAIN.	
	59_452_3_1	P	And I was like speeding off my nut, y'know?	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_453_1_1	D	Mm	
	59_454_1_1	P	My- for the last two ah- or for the last two months, I suppose, particularly in the last few weeks, I felt really weak all around here.	P
	59_454_2_1	P	Y'know, my kidneys, my belly, y'know?	
	59_455_1_1	D	Mm, mm	
	59_456_1_1	P	And I'm- I feel bloody skinny	P
	59_456_1_2	P	and I feel like I'm gonna get knocked.	
	59_457_1_1	D	You look skinny.	D
	59_457_2_1	D	Even though it's two kilos,	
	59_457_2_2	D	you look skinny to me.	
DECLARE: declare recommendation/pref	59_458_1_1	P	I know, I'm really boney here and stuff	P
	59_459_1_1	D	I know.	
	59_459_3_1	D	Exactly.	
	59_459_4_1	D	Yeah.	
	59_460_1_1	P	And that's where I can feel it, y'know?	
	59_460_2_1	P	And I- y'know, my program is [[ ]]	P' P
	59_460_2_2	P	[[that I must eat for a start]].	
	59_460_3_1	P	I must focus on eating.	
	59_460_4_1	P	I am very happy at the moment, you know?	P
	59_460_5_1	P	There's really nice stuff happening.	
	59_460_6_1	P	And I'm like ooh,	
	59_460_6_2	P	that's really great.	
	59_460_7_1	P	And I don't- no, I don't really want	P
	59_460_7_2	P	to be lying around in a terrible fit from all three	
	59_461_1_1	D	Okay.	
	59_462_1_1	P	All three combinations.	
	59_464_1_1	P	Yeah.	
DECLARE: elicit/ amplify recommendation	59_465_1_1	D	Is that what I'm hearing?	D'P
	59_466_1_1	P	Yeah.	
	59_467_1_1	D	Is that what you'd like?	
	59_468_1_1	P	Yeah.	
ENUNCIATE: enunciate decision	59_469_1_1	D	Okay.	
	59_469_2_1	D	That was easy.	
	59_470_1_1	P	Was, wasn't it?	
	59_472_1_1	P	Oh God.	
	59_473_1_1	D	Okay.	

There follows a discussion of other details, and it is only after the patient has made the decision to avoid the proteases at this stage, largely because they might interfere with her focus on eating well, that Karen and Joan discuss what Karen might do were she in Joan's position. It is somewhat surprising that she declares her preference (cf. Sarangi and Clarke 2002), but given that she does this, perhaps it is no surprise that she declares her preference to be the same choice as the one she has arguably helped Joan to make. It must be stressed, however, that in parts of Karen and Joan's consultations not shown here, considerable talk was devoted by Karen to arguing against the dual therapy option which turns out to have been her preferred option. This passage of talk also seems to serve as a means of reflecting on and committing to the decision that has been made – where additional or more elaborated argument is marshalled to the rationale for choosing dual therapy, even though the decision has been construed as having already been taken. However, it is always problematic to speak of "after the decision has been taken", because it would have been quite possible, according to the loosely structured generic structure outlined in Chapter 5, for the patient to have taken a recursive move back into the earlier phase and "undone" the Enunciation, if the doctor's response about "what she would do in the patient's circumstances" had not reassured the patient about their decision.

Table 6.6 Extract 4 from Consultation 59: Karen and Joan

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
DECLARE: elicit preference	59_725_1_1	P	But I mean y- you can't go about that thing	D
	59_725_1_2	P	without forming your own opinion.	
	59_726_1_1	D	Me?	
	59_727_1_1	P	Yeah.	
DECLARE: declare preference	59_728_1_1	D	I wouldn't take the proteases at the moment.	
	59_728_2_1	D	It's really hard for me to say that.	D" D
	59_728_3_1	D	I don't have the virus.	
	59_729_1_1	P	Yeah.	
	59_730_1_1	D	I'm not walking around every day with the knowledge [[ ]]	
	59_730_1_2	D	[[that this is what's happening inside my brain]].	D' D

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	59_730_2_1	D	And, from my own knowledge of [[how it feels [[to be seriously ill]]]], that changes everything [[that you do and think]].	D' D' people
	59_730_3_1	D	So,	
	59_731_1_1	P	Mm.	
DECLARE: P autonomy	59_732_1_1	D	I'm not here	D"D
	59_732_1_2	D	to tell you	
	59_732_1_3	D	what I would do.	
	59_732_2_1	D	I'm not you.	
	59_733_1_1	P	Yeah.	
AMPLIFY: values calibration	59_734_2_1	D	I mean for some people mm, I dunno, looking funny is the worst thing [[that could happen to them]]	some people
	59_734_2_2	D	and for other people vomiting is the worst thing [[that can happen to them]].	other people
	59_735_1_1	P	Mm.	
	59_737_1_1	P	Yeah.	
	59_737_2_1	P	That's why they vomit. ((laughs))	
	59_738_1_1	D	Yeah, exactly.	
	59_739_1_1	P	I have been for years.	
	59_739_2_1	P	Tragically true.	
	59_739_3_1	P	I haven't been sick for ages, though.	
	59_740_1_1	D	Does that make sense to you?	P
	59_741_1_1	P	Yeah.	
	59_741_2_1	P	No, that's right.	
	59_741_3_1	P	And, I mean people are [[the things that make me alive and me- y'know, me function]] .	people
	59_741_4_1	P	And if I had to have- walk around with KS on my face,	
	59_741_4_2	P	I'd be very, very unpleasant.	
	59_741_5_1	P	I'd be an unpleasant person.	
	59_742_1_1	D	That- that's what I'm talking about.	D
	59_742_2_1	D	That's the sort of stuff I'm talking about.	
	59_742_3_1	D	Yeah.	
	59_743_1_1	P	At least when you're skinny,	
	59_743_1_2	P	you can wear sexy tight pants.	
	59_743_2_1	P	((laughs)) Okay, I'm gonna eat,	
	59_743_2_2	P	I'm gonna eat. ((Laughs)) ...	
ENACT: describe treatments	59_744_1_1	D	Now the AZT dose [[I'm giving you]] is a s:- is not a big dose.	D
	59_744_2_1	D	It's only two hundred and fifty milligrams, twice a day.	
	59_744_3_1	D	That's five hundred milligrams.	
	59_744_4_1	D	One of the reasons [[I'm doing that]] is you're only sixty kilos.	
	59_744_5_1	D	Which is not giant.	

Before closing off the discussion of this rich deployment of representational resources for construing agency, it is important to summarise the relationship between the interrelating strands of agentivity and passivity mentioned at the beginning our discussion of Joan and Karen's interaction, and how these are brought together in a shared decision.

We have already noted how the patient's (Joan's) identity is construed in terms of current and potential identity, involving a contrast (and a choice) between passively and actively responding to HIV. Arguably this setting up of contrast as choices is a key rhetorical resource for the doctor in the process of persuading the patient to take up treatment, much in the same way that Sarangi and Clarke (2002) describe the construction of contrast as implying choice in genetic counselling. But interwoven into these identity choices in Karen and Joan's discourse is another set of contrasts regarding the patient's identity vis-à-vis HIV itself. There is an interaction between these sets of choices about the patient's identity which is crucial to the joint process of making sense of the viral load, the treatment information and the patient's lifeworld, in order to choose a treatment regimen, and this interaction can be brought out through analysis of the representational strategies employed by Karen and Joan.

One way of considering the variation in these kinds of representation practices is to consider degrees of fusion/nondifferentiation between patient and virus. This can be mapped as a cline beginning with 1) representation as two distinct participants – e.g., you tolerate a bit of virus; then 2) separable possessivation – e.g., you've got a really bad viral load; 3) more permanent possessivation – e.g., your viral load is 100,000/ your viral load is undetectable (i.e., even when virus = 0, you still have a viral load); and finally 4) identity fusion – e.g., I'm down to 10,000. (See also Appendix 3.)

Not surprisingly, Joan and her virus are repeatedly presented as *associated.* More importantly, this association often takes the form of *undifferentiation,* between the patient and the virus, and *overdetermination* of the patient's identity in terms of the virus (e.g., "*I get down to zero*", "*I get down to less than a thousand*" at turn 123 in consultation 59). Here the patient is represented as the virus. The grammatical identity of the patient and the viral load are fused (cf. Halliday 1998).

This particular strategy for undifferentiation is of course very common and often highly naturalised, involving the core linguistic principles of metonymy and meronymy. Such strategies are used for many different rhetorical purposes, including in the spoken discourse of physical science, where the personal pronoun 'I' is often held to represent an "indeterminate referential identity" which "blurs the boundaries between the animate subject (physicist) and the inanimate object (physical entity/system)", such as a particle or field (Ochs, Gonzales and Jacoby 1996: 358). The example Ochs and colleagues use for the title of their paper is "*When I come down I'm in the domain state*". In Consultations 58 and 59, and indeed throughout the corpus, we see something similar in the *overdetermination* of the patient in terms of weight ("*I'm about 63*", "*You're now 61*" in Consultation 58, turns 2 and 3, and also in Consultation 59, turns 457, 458, 743 and 744). In the context of making decisions about treatment, these types of constructions appear to be associated with the construal of a 'sick identity', in the simultaneous construction, choice and display of identity (Giddens 1991, Lemke 2000b). Compared with other ways of talking about self and viral load, representation practices which involve overdetermination can be interpreted as contributing to what has been called the 'somaticisation' and 'technologisation' of risk management in HIV (Flowers 2001, Davis et al. 2002), although it must be emphasised that no consistent or isomorphic relationship between any one instance of representation and a speaker's personal sense of identity is implied.

Research on a number of illnesses suggests that the adoption of a 'sick' identity by patients may be – perhaps counterintuitively – a barrier to taking up prescribed treatments: some people reject diagnosis or refuse treatment because to accept it would be to accept a 'sick' identity (Adams et al. 1997, Goldman and Mclean 1998, Race et al. 1997). One strategy used by both providers and consumers of medicines in working through this issue is to re-construe treatment in holistic terms, as something for the whole self, which maintains health, rather than attacking a specific disease, and which therefore does not necessarily imply a 'sick' identity. Arguably, the consultations presented here between Joan and Karen instantiate such a reconstrual of treatment as a resource, within a complex negotiation of the patient's identity as physically vulnerable and yet in other ways powerful and agentive.

Figure 6.17 below attempts to capture, in the form of a cohesive harmony diagram, the way in which the strands of talk which represent overdetermine and undifferentiate the patient in terms of weight and virus, interact with each other and with those representations which construe her as self-activating and agentive. It is necessarily simplified and reduced to representing key sections of the two transcripts: sections which, in my view, scaffold the whole decision.

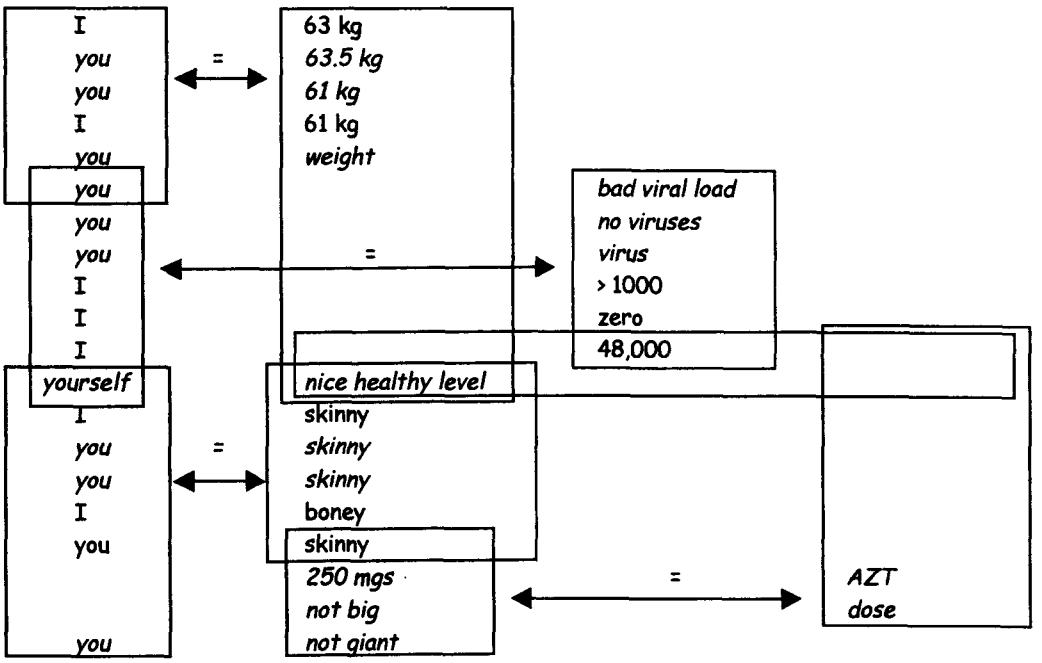

Figure 6.17 Key aspects of cohesive harmony in Consultations 58 and 59.

Figure 6.17 shows the relationship between key message elements representing the patient's self, weight, viral load, and AZT dose, as they unfold in the consultations between Karen and Joan, adapting slightly Hasan's method of displaying cohesive ties between lexical items and the interactions between chains of ties (Hasan 1984, Hoey 1991). Reading from the left and downwards, we have a chain of references to the patient which run through the two consultations. Both 'I' and 'you' refer to the patient, since both the patient's and the doctor's turns are included. Elements from the doctor's turns are italicised. Note that the patient's first-person voice is projected by the doctor at times. Moving to the second column, references to weight and

skinniness are shown as forming a persistent chain of reference throughout the two consultations. Moving to the third column, reference to viral load levels are shown as another chain. Finally, references to treatment regimen and dose are shown as a fourth chain.

Elements in the longer chains are boxed in order to indicate which instances of that chain interact with instances of another chain. This shows how Karen's and Joan's decision-making begins with the patient's identity chain interacting with the weight chain. Interactions between the patient's identity and the viral load chain follow, then give way back to interactions between patient and viral load. The decision-making is finalised with the treatment chain interacting with the weight chain.

In the centre of the diagram, and arguably in the metaphorical centre of the cohesive relations between these and all the other strands of meaning that come together into a particular treatment choice, is an interaction between one element in the patient's identity chain, "yourself", and the element "a nice healthy level". This reference to a "healthy level" connects the weight chain with the viral load chain, and the treatment chain, through hyponymic ties with each chain. It is directly after this crucial turn from the doctor that the patient declares her choice of dual therapy and her rationale for this choice, the priority of eating, which would be much harder on a triple-drug regimen.

The final point to add is that at this critical juncture, which links weight, viral load, and treatment options, the doctor represents the patient as highly agentive:

59_449_1_1 D The trick is to keep yourself at a nice healthy level.

This construction positions the patient as both a *self-activating participant* (the one who does the keeping) and as a *subjectified participant* (the self which is kept healthy). This agentive representation of the patient has its own cohesive ties with similar representations throughout the two consultations (though it is not possible to add that level of detail this to the diagram without making it illegible). This additional layer of cohesion in turn links the construal of the patient as vulnerable and passivated, with the construal of the patient as having the capacity and resources

to act, to change her health, and enjoy her life more. The complex representation of the patient's agency throughout these two consultations appears to encourage the patient to participate in and own the decision, and it is evident that she shapes the decision pathway and outcome. This patient draws on the resources of the doctor, and on treatment information and other institutional resources, but challenges those perspectives with her own view at times. Unfortunately we do not know whether the upbeat scenario thus depicted was realised for this patient, and it will be important in future research to explore patients' experience of such styles of decision-making, their effects on ease of treatment implementation, adherence, and so on, and perhaps something like a "promise/ outcome ratio".

6.4.2 Patient's unilateral decision not to treat

A contrasting discussion about initiating combination therapy is found in a pair of consultations about re-initiating antiviral treatment. Patient Brian's potential and actual responses to the question about treatment are construed not in terms of his identity, as we saw for the patient Karen, but in terms of his experience (a bad experience with the early antiretroviral drug AZT). This consultation took place approximately 12 months before the conversation between Karen and Joan, and before the widespread availability of combination therapy, before viral load could be routinely monitored, and before the institutional position on treating with antivirals became as codified as it had become by late 1996. These reasons may explain *why* Tony, the doctor, does not press Brian for more than a personal response in terms of preference; but we are also interested in *how* a unilateral decision is constructed, and the role in this of how social actors are represented. The decision-making between Brian and Tony provides a good example.

In the following extract, the issue of initiating antiviral treatment is raised by the doctor, and responded to negatively by the patient.

Table 6.7 Extract from Consultation 48: Brian and Tony

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: check markers	48_85_1_1	D	Now, has Hazel checked your t-cells recently?	Hazel (other doctor)
	48_86_1_1	P	Umm, I was checked-	
	48_86_1_2	P	I had a blood done about a fortnight ago.	
	48_86_2_1	P	I've got to make an appointment [[to go in and see what those results are]].	
BEARINGS: update re Rx	48_87_1_1	D	And you're not on any antiviral drugs now?	
	48_88_1_1	P	Just y'know umm Bactrim.	
	48_89_1_1	D	Just Bactrim.	
	48_90_1_1	P	Bactrim, ye[ah.	
	48_91_1_1	D	And you've done, you have been on AZT and ( )	
	48_92_1_1	P	I have been on it but it made me very sick.	
	48_93_1_1	D	Sick on the stomach?	
	48_94_1_1	P	Yeah, oh yeah.	
PROPOSE Rx	48_95_1_1	D	Are you interested in any of the others?	P
ENUNCIATE treatment	48_96_1_1	P	No, not [interested at all.	
	48_97_1_1	D	No.] Ok.	
	48_98_1_1	P	. .	
PROPOSE Rx	48_99_1_1	D	Cos there are some other ones [[that may not do that]].	
	48_100_1_1	P	Yeah, yeah.	
DECLARE preference	48_101_1_1	D	Has she talked to you about that?	Hazel
	48_102_1_1	P	Yeah, we have talked about it,	P+ Hazel
	48_102_1_2	P	but umm, I'd rather not play around with y'know these treatments [[that we don't know much about]].	P [[P+D/ institution]]
AMPLIFY: roles	48_103_1_1	D	Every now and again I might just talk to you about them, whatever's new	D
	48_104_1_1	P	[Yeah.	
	48_105_1_1	D	at the] time.	
	48_106_1_1	P	Yeah.	
	48_107_1_1	D	Um.	
AMPLIFY shared technical code	48_108_1_1	P	I, I get Talkabout and a few other magazines.	P
	48_108_2_1	P	I did read up and see what there is but ..	
DECLARE Rx recommendation	48_109_1_1	D	(Yeah) the Bactrim's vital though isn't it?	D"P
	48_110_1_1	P	Mm-hmm. [Oh yeah	
	48_111_1_1	D	And that's impressive hey? ((referring to Brian's cough ?))	
	48_112_1_1	P	Being an asthmatic (there's there are no hope for you really)	
	48_113_1_1	D	Yes. OK. Great. .. And how are the legs going, the um the numbness?	

As the doctor foreshadowed in turn 103, he returns to this topic two visits later in Consultation 50, below.

Table 6.8 Extract from Consultation 50: Brian and Tony

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: update	50_42_1_1	D	Have they given you anything at ((name of clinic)) for that ((facial dermatitis))?	clinic
	50_43_1_1	P	Um, no.	
	50_43_2_1	P	All I'm taking is Bactrim,	
	50_43_2_2	P	so nothing for the skin, no.	
PROPOSE Rx	50_44_1_1	D	Have they talked to you about any medications antivirals or.	Clinic
DECLARE recommendation	50_45_1_1	P	**Well, umm, like I said.**	P"P
	50_45_2_1	P	**I tried the AZT**	
	50_45_2_2	P	**it made me sick**	
	50_45_2_3	P	**and I'd, I would really rather just y'know stick with the ah PCP**	
	50_45_2_4	P	**and not take drugs [[that we're not too sure about]].**	**P [[P+D / institution]]**
	50_46_1_1	D	Yeah.	
AMPLIFY	50_47_1_1	D	So you are pretty happy with your treatment at the moment?	P
	50_48_1_1	P	Yes, yes, I'm quite happy.	P
BEARINGS propose observation	50_49_1_1	D	How's your mouth going?	
	50_50_1_1	P	Umm. Fine.	
	50_51_1_1	D	Let's have a quick look.	D
	50_50_2_1	P	I haven't had any umm thrush	P
	50_50_2_2	P	and ah it's good.	
	50_51_2_1	D	The only reason, my interest is [[that it's probably a ( )]]	D
	50_51_2_2	D	because you are going to ((name))	
	50_51_2_3	D	they can look after your medical side.	
	50_52_1_1	P	Yeah.	
	50_53_1_1	D	But umm.	
	50_53_2_1	D	Just poke your tongue to the left, right,	
DIAGNOSE	50_53_2_2	D	ah actually you've got a bit of oral thrush there.	D
	50_53_3_1	D	Just say Aah	
	50_54_1_1	P	Aah	
	50_55_1_1	D	Yeah, the oral thrush.	
PROPOSE Rx	50_55_2_1	D	Thing being is [[that, there's a tablet]],	
BEARINGS	50_55_2_2	D	do you know if your mouth tastes funny?	?P
	50_56_1_1	P	Ah not really.	
PROPOSE Rx	50_57_1_1	D	Because you've got thrush in your mouth	
	50_57_1_2	D	plus you've got this Dermatitis on your face	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	50_57_2_1	D	There's a tablet	
	50_57_1_3	D	there's a tablet	
	50_58_1_1	P	Mm.	
AMPLIFY	50_59_1_1	D	Does this worry you much, the rash?	rash
	50_60_1_1	P	Well, y'know it does make me a little bit self conscious .	rash
	50_60_2_1	P	Yes. yes.	
	50_61_1_1	D	There's a tablet [[you could take one a day]]	
	50_61_1_2	D	that will stop the thrush in your mouth	
	50_61_1_3	D	and fix up the rash on your face.	
	50_62_1_1	P	Mm.	?
DESCRIBE Rx	50_63_1_1	D	That's umm not an anti-viral	
	50_63_1_2	D	it's a anti-fungal.	
	50_64_1_1	P	Right	
	50_65_1_1	D	Because the rash on your face is umm partly a fungal thing.	
	50_66_1_1	P	Right.	
	50_67_1_1	D	And that's why the Cortisone only makes it a little bit better,	
	50_67_1_2	D	it doesn't quite fix it.	
	50_68_1_1	P	Yeah, yeah.	
	50_68_2_1	P	It it takes it away	
	50_68_2_2	P	and then it will reappear	
	50_68_2_3	P	as I said yeah.	P
DECLAR: Elicit declaration	50_69_1_1	D	How would you feel about [[taking a tablet [[that would fix that, that up]]]]?	P
	50_70_1_1	P	Well, I wouldn't mind taking another	P
	50_71_1_1	D	You wouldn't have to take it quite every day,	
	50_71_1_2	D	every couple of days may be all right.	
	50_72_1_1	P	Okay.	
	50_73_1_1	D	Would that be okay?	
	50_74_1_1	P	Yeah, yeah.	
	50_74_2_1	P	That'd be fine	

Here Tony, the doctor, appears to have an agenda to get the patient to take antivirals but the patient does not want to pursue this agenda. There are clear signs from Brian, the patient, that he has a firm view on the issue, as he elaborates the negative polarity of his response ("*No*", plus "*not interested* plus *at all*" at turn 96) and employs "silent disagreement" (Aronsson and Sätterlund-Larsson 1987) at turn 98. The doctor attempts to keep the topic going after this response, and again after a further attempt to close down the topic, but is not successful in achieving anything other a confirmation of the patient's disinclination to use antivirals.

In terms of how this decision and the respective roles of the doctor and patient are represented and enacted, the treatment question is construed as a matter of the patient's wishes and never moves out of that domain. The topic is raised with a desiderative mental process (Halliday 1994/1985) or a Figure of Sensing: wanting (Halliday and Matthiessen 1999) – *"Are you interested in of the others?"*, repeated with the patient's response *"No, not interested at all"*, and again with *"I'd rather not play around with y'know these treatments..."*.

There is no framing of the treatment decision in terms of institutional policy, research findings, or the doctor's or patient's interpretation of these, although as the patient notes he has talked to another of his doctors about this topic and she may have covered those issues at length earlier. Nevertheless it is salient that in this conversation, when the doctor would appear to be attempting to influence the patient to take treatment, there is no revisiting of these issues and no persuasion. There is no semantics of obligation or perception, and little elaboration of each person's perspective, although the patient does nominate an HIV treatments magazine by way of indicating that his decision is informed, and by way of closing the topic down, possibly heading off any expansion on the matter by the doctor (if so, successfully).

The new treatments are represented by the patient as a *passivated* Phenomenon with an embedded clause as qualifier ("these treatments [[that we don't know much about]]" in Consultation 48 at clause 102_1_2). In the reprise of this scenario in Consultation 50 at clause 45_2_4, a very similar set of resources is used by Brian in maintaining and upgrading his agentive role. In both consultations, Brian represents the state of institutional knowledge about antivirals as something with which he is *personally associated* as an *activated participant*, but the grammatical embedding in both of these messages depicts uncertainty as a quality of the treatments.

One effect of attaching the uncertainty to the treatments in this way instead of attaching it to human epistemic agents is to draw attention away from the perspectival nature of what is/was known about treatments, thus drawing attention away from the particulars of the arguments for and against different approaches. This in turn contributes to closing down the interpersonal space for negotiating views about treatments (cf. White 2000). All that is available interactionally is statement and restatement of these disparate and independent views. The embedding of

perspectives about treatment in Consultations 48 and 50 needs to be contrasted with the projection of views discussed in Karen and Joan's consultations (Consultations 58 and 59) as contrasting ways of representing semiotic agency. Although the evidence of these consultations is not conclusive, the use of these different strategies appears to be related to whether discussion of the patient's and doctor's views results in the development and integration of views or merely the need for a choice between views.

From this perspective, note how the doctor stresses the importance of taking Bactrim (an antibiotic not an antiviral) for preventing PCP, and the doctor successfully positions this as a shared view through using the interactive move of a confirmation question (turn 109 in Consultation 48). Here too there is no change in views, only restatement, but the doctor's emphasis on Bactrim has been worked into the patient's policy statement in the second version of this discussion of antivirals in Consultation 50; this needs to be counted as a display of mutual alignment and agreement on related matters (cf. Linell 1990). Note too the doctor's ability to enhance alignment at turn 50_63 by clarifying that his new treatment proposal is not about antivirals but antifungals, having picked up on the patient's silent disagreement at turn 50_62.

There are many other features which should be commented on but for lack of space. I will note two important features which contrast with Karen and Joan. The first point is that, in terms of their representations of themselves and each other, Brian and Tony remain highly *differentiated* throughout the discussion of antivirals and the follow-up discussion of antifungal treatment. If anything, the patient is *activated* by the doctor more than the doctor activates himself, although as mentioned already the patient's semiotic agency stays within the realm of *desideration,* i.e., *wanting*. These features make Tony and Brian's style a very different decision-making style from Joan and Karen's. However, the relationship between representation and enactment is similar. In Tony and Brian's consultations the unilateral representation of agency is accompanied by a strongly unilateral sense of who declares and enunciates decisions. In Joan and Karen's consultations, there is a strong representation of agency as bilateral and interdependent, and the moves of

deliberation, declaration and enunciation of the decision to treat are facilitated by the doctor but articulated in substance by the patient.

The second contrastive feature to note is that the sense of identity-as-project (cf. Giddens 1991) is absent in the consultation between Tony and Brian. Patient Joan's warrant for speaking and choosing about treatment is largely constructed in terms of projecting a future for herself, and in terms of the ethics of self-determination (as both an obligation and a right). These themes are realized in large part through the semantics of agency, time, dependency relations, and mutual projection of voices, as discussed above. In patient Brian's case, there is a greater orientation to his past experience – his personal experience of taking AZT, and his existing familiarity with the discourses about treatments, independently accessed through the HIV community press. This is not to say that the concept of identity itself is not an important factor in how Brian and Tony's consultations unfold, but it is not recontextualised by them as part of the Field that their consultations construe.

One might be tempted to label Tony and Brian's style of decision-making as informed choice, but the repeated confirmation of views, with little elaboration or explanation, points to a key problem of the idea of informed choice as it is defined in current models. Under the model of informed choice, there is a requirement for the doctor to ascertain that the patient is making an informed choice but no real mechanism for ascertaining whether this is the case or remedying it if it is not the case, other than to engage in practices of elaboration and negotiation which would then move such an encounter into the "shared decision-making" category.

6.5 Reviewing treatment and compliance

Having illustrated decision-making practice regarding the initiation of treatment, I now turn to examining the way in which doctors and patients construe each other as social agents in the process of reviewing existing treatment decisions, focussing first on a series of consultations between doctor Martin and patient Philip.