6.5.1 Negotiating roles in reviewing treatment: Martin and Philip

Table 6.9 Extract 1 from Consultation 1: Martin and Philip

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
AMPLIFY : shared non clinical values	1_1_1_1	P	He's a cute little thing isn't he, but.	
	1_2_1_1	D	He is.	
	1_3_1_1	P	Can't believe	P
	1_3_1_2	P	he's straight.	
	1_4_1_1	D	Don't want to find out.	D
BEARINGS: Update	1_5_1_1	P	I've just seen ((name of specialist))	P?
	1_6_1_1	D	Right.	
	1_7_1_1	P	((coughs)) Excuse me.	
DIAGNOSE non HIV specific	1_8_1_1	D	Whoa.	
	1_8_2_1	D	How long have you had that?	
	1_9_1_1	P	Oh forever.	
	1_10_1_1	D	Hasn't been that thick.	
	1_11_1_1	P	Mm it's probably a little bit worse at the moment.	
	1_12_1_1	D	Yeah.	
	1_12_2_1	D	I might listen to your chest in a tick.	D
	1_13_1_1	P	Okay.	
BEARINGS: Update	1_14_1_1	D	What did ((name of specialist)) suggest?	other doctor
PROPOSE report treatment rec	1_15_1_1	P	Well um, obviously change the drugs.	
	1_15_2_1	P	He suggested [[DDI (mm-hmm) um, oh god .. ritonavir, and	
	1_16_1_1	D	Mm-hmm.	
PROPOSE: identify options	1_17_1_1	P	I can't remember the other one ..	
	1_17_1_2	P	one's six pills twice a day,	
	1_17_1_2		is that ritonavir?	
	1_18_1_1	D	Yes.	other doctor
	1_19_1_1	P	And the other one's one pill twice a day.	
	1_20_1_1	D	3TC?	
	1_21_1_1	P	No, it's a protease.	
	1_21_2_1	P	It's not licensed,	
	1_21_2_2	P	it has to be ordered I think	
	1_22_1_1	D	Ah nelfinavir?	
	1_23_1_1	P	Yes I think that could be it.	
	1_23_2_1	P	Nelfinavir . . mm anyway[1].	
	1_23_3_1	P	And because of my warfarin he's not sure	

[1] Martin and Philip do not get the set of drugs quite right. The final recommendation appears to be ddI, ritonavir, and nevirapine (not nelfinavir), which fits with the prescribing practice of choosing one nucleoside analogue, one protease inhibitor, and one non-nucleoside reverse transcriptase inhibitor.

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	1_23_3_2	P	if they need a directive ( )	
	1_23_3_3	P	<< he couldn't get a hold of the pharmacist>>	
	1_24_1_1	D	Yeah, not that I'm aware of, but I ( )	D
PROPOSE : report treatment rec	1_25_1_1	P	Um he said	other doctor
	1_25_1_2	P	have a week off	
	1_25_1_3	P	not to have any drugs for a week	
	1_25_1_4	P	and see him next week.	
	1_25_2_1	P	It's a bloody nuisance, [[having to come back again]] ((laughs)).	
	1_25_3_1	P	So I'm going to be drug free for a week.	

The extract above, from Martin and Philip, re-presents the conversation seen earlier in this chapter. There follows a discussion of a number of other issues, and then the HAART treatment plan is summarised before the consultation is terminated, as shown in the extract below.

Table 6.10 Extract 2 from Consultation 1: Martin and Philip

GSP phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: enunciate decision	1_110_1_1	D	All right.	
	1_110_2_1	D	Well.	
ENACT defer RECAP plan	1_111_1_1	P	I'm going to see ((name of specialist)) next week so and-	P ?
ENACT defer treatment supply	1_111_1_2	P	Start the pills then.	
	1_113_1_1	P	I'll start the new drug	
	1_113_1_2	P	and I'll see you,	
	1_113_1_3	P	I'll being seeing you on the Tuesday after that anyways.	
MARKERS: propose obs/ test	1_114_1_1	D	And [[what I'd like to do]] is a viral load about a fortnight after you've been on the pills.	D
	1_115_1_1	P	Okay.	
	1_116_1_1	D	'Cause I like to do one two weeks after, four weeks after,	
	1_116_1_2	D	and then we'll go from there.	
	1_117_1_1	P	Okay.	
MARKERS: project evaluation	1_118_1_1	D	And if we can see [[the viral load plummeting down]]	D+
	1_118_1_2	D	that'll be delightful.	as institution

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	1_119_1_1	P	Right.	
	1_120_1_1	D	And if it doesn't	
	1_120_1_2	D	then after eight weeks get you back	
	1_120_1_3	D	to see ((name of specialist))	
	1_120_1_4	D	and juggle the pills around.	

In Consultation 1 above, Philip is reporting back to his GP, Martin, the recommendations of a specialist. Presumably the specialist will provide the script for these treatments, but the GP will be responsible for monitoring their effectiveness, at least in part. It is interesting to note how Martin's linguistic choices here construct a sense of agentive equivalence between himself and the specialist, through representing the specialist's recommendation as a suggestion, and representing his role in monitoring this treatment as one *personalised, individuated, and preference* (*"what I'd like to do*" at turn 114). Martin also tends to represent himself as an *assimilated* joint actor (e.g., clauses 16_1_2 and 18_1_1), where it is ambiguous whether the patient is included or excluded in this joint agency. This is particularly the case with respect to *semiotic action* (e.g., "seeing *the viral load plummeting down"* at turn 118), but also with the *materialised* construals of treating and managing treatment (*"juggling"*, *"going from there"*). The materialisation of these processes produces an equivocal balance between agentivity[1] and lack of control over events on the part of the decision-makers. On the one hand, *"juggling the pills around"* renders the decision-makers grammatically the agents of this process, but there is an inherent semantics of tenuous control suggested by the process "juggling". Additionally, there is recurrent ellipsis that construes much of the action as happening without a particular actor being specified. This, in conjunction with the ambiguity between personalised "we" and institutional "we", leaves the construal of agency often rather *indeterminate* here and elsewhere in Martin and Philip's consultations. An example is presented from turn 120 in Table 6.11:

[1] The materialisation of semiotic processes may be used to increase their activation; cf. Whorf's example of "grasping ideas" and the spatialisation of thought (Whorf 1956).

Table 6.11 Examples of doctor's ellipsis of agent in Consultation 1

Clause ID	*Text*	
	Actor	*Process*
1_120_1_1	it	doesn't (plummet down)
1_120_1_2	(we'll? I'll?)	get you back
1_120_1_3	(you)	to see the specialist
1_120_1_4	(we'll? they'll? you to)	juggle the pills around

The patient, however, displays a somewhat different construal of events and relations. Philip depicts the specialist as a having a more direct and agentive role in the treatment decision than the role of "suggestion" depicted by Martin. Philip represents the specialist as semiotically agentive by constructing him as the *projecting agent* of a number of *imperating* or direct imperative locutions (turns 15 and 25). These become additionally charged with dynamism since they represent the generic phases of *declaration* and *enunciation*. The patient represents himself as *personalised, individuated*, and *associated* with the specialist in his own right, rather than via the GP. For instance, Philip states/declares what he will be doing with respect to the specialist's visits, rather than seeking confirmation from Martin about the specialist's treatment suggestion. Where Philip *activates* the specialist, he represents himself as *beneficialised*, in the sense of being the receiver of advice or directives. However, there is also a sense of being *passivated* by the specialist's advice, associated with the use of the imperative/imperating locution with himself as implied Actor at clauses 1_15_1_1 and 1_25_1_2.

Misalignment of discourses and treatment priorities

This and subsequent consultations between Martin and Philip are notable for their tenor of cordiality. They are also notable for their display of shared gay community membership and identity, as witnessed in the opening joint appraisal of a man they are both attracted to, along with a high degree of shared technical coding, as

witnessed by their ability to jointly reconstruct the drug regimen recommended by the specialist.

Despite this, Martin and Philip's perspectives on combination therapy and on their therapeutic relationship appear to be misaligned in a number of crucial ways. I have already indicated some misalignment in terms of their respective construals of agentive role and the reciprocality of such roles (with respect to patient, GP and specialist). The extracts below from Consultations 2 and 3 demonstrate the nature and effects of such misalignment, especially from the perspective of treatment decisions forming an ongoing decision cycle as outlined in chapter 3.

It is necessary for doctors and patients to be able to bring different discourses of health together in evaluating clinical evidence, in particular with respect to evaluating viral load and using such evaluations to make treatment decisions. This diversity in discourses of health can be described in a number of ways, as professional and lay (ten Have 2001); professional and institutional (Sarangi and Roberts 1999); voice of medicine and voice of the lifeworld (Habermas 1984, Mishler 1984); and others. Elsewhere my colleagues and I have described distinctions between the discourses of health measurement, health care and health experience (Moore et al. 2001; see appendix 4), and I will draw on that work here.

The *discourse of health measurement* embodies the values and practices of the laboratory, and is dominated by a biomedical model of disease and its processes as objective, measurable, repeatable and generalisable. The *discourse of health care* centres on treatment goals and treatment decisions. It typically involves the foregrounding of inference and hypothesis, especially interpreting observations in terms of cause and effect, and predicting effects that can be made to happen in the future. In the *discourse of health experience*, health tends to be construed as sense-driven, privileged knowledge about a phenomenon which is a positive property, not merely the absence of disease. In this discourse, health is fundamentally a global property (it may be the kidney that is diseased, but it is the person who is sick). These three related but distinct discourses exist as items within the order of medical discourse in general (cf. Fairclough 1995) and represent different "amalgams of ways of talking, valuing, thinking, believing, interacting, acting ... writing and reading, together with various props in the world", which in HIV medicine would be things

like syringes, pathology laboratory equipment, and report forms on screen or paper (Gee 1992). These discourses interact, along with other discourses in medicine, to inform HIV medicine in a distinctive way.

Compared with Joan and Karen, Martin and Philip have difficulty in identifying and managing shifts between these discourses in their consultations, and Martin tends to direct the decision-making about combination therapy rather strictly in terms of the discourse of health measurement, resulting in a decision-making style which is not as comprehensively shared as it might be.

The types of representational practices discussed in this chapter appear to be an important site for negotiating alignment, and these together are important for enhancing shared decision-making. Where interactants conflict in their construals of the type and locus of agency in their joint endeavours, there is likely to be substantive misalignment or miscommunication with regard to treatment options, preferences and plans. A crucial factor here is the degree to which there is some representation and local recontextualisation of each others' lines of enquiry, through projection and related strategies. As the coding of semiotic agency in the text extracts below indicates, the discourse strategy of mutually projecting each other's voice and views is not prominent in the talk between Martin and Philip.

Table 6.12 Extract from Consultation 2: Martin and Philip

GSP phase	Clause ID	Spkr	Text	Semiotic agent
MARKERS: lab results: offer/ demand results	2_53_3_1	D	Now once I've done this	D
	2_53_3_2	D	I'll look up your old viral load.	
	2_54_1_1	P	Twenty-five thousand five hundred	P
	2_55_1_1	D	Ah thank you.	
	2_56_1_1	P	((laughs)) But I didn't get T-cells	
	2_56_1_2	P	so I don't know [[what that was]] so	
	2_57_1_1		ooh]	
MARKERS: situate results	2_58_1_1	P	Out of interest I just write it down.	
	2_58_2_1	P	You didn't have the result.	
	2_59_1_1	D	Right, just had the viral load.	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
MARKERS: evaluate results	2_60_1_1	P	But I feel all right	-> D
	2_60_1_2	P	so y'know that's the main thing isn't it?	
	2_61_1_1	D	Yes. ..	
	2_61_2_1	D	That's half way there.	
MARKERS: values calibration	2_62_1_1	P	Yeah well this is only part of the picture isn't it?	
	2_63_1_1	D	Exactly.	
	2_64_1_1	P	If I was feeling lousy	P
	2_64_1_2	P	I'd be concerned	
	2_64_1_3	P	but since I don't.	
	2_65_1_1	D	Yeah.	
	2_65_2_1	D	I was going to say	D"D
	2_65_2_2	D	even if your results were fantastic	
	2_65_2_3	D	but you were still feeling lousy	
	2_66_2_1	P	Yeah	
	2_67_2_4	D	and sleeping all day	
	2_67_2_5	D	um I'd want to do something about the pills	
	2_67_2_6	D	and change it anyway.	
	2_68_1_1	P	Mm.	
	2_69_1_1	D	Okay, thank you.	
	2_69_2_1	D	**Now twenty-five thousand.**	D
	2_69_3_1	D	**All right then Phil ultimately if it's less than ten**	
	2_69_3_2	D	**I'm going to be .. happy.**	
	2_70_1_1	P	Mm	
	2_71_4_1	D	Less than five would be ideal.	
	2_71_1_1	P	Zero would be	
	2_72_1_1	D	Even better.	
	2_73_1_1	P	Mm.	
	2_74_1_1	D	( ) ... yeah.	
MARKERS: explain results	2_75_1_1	P	Great, thank you.	
PROPOSE: defer decision	2_76_1_1	D	**So if we can get it right down to less than ten thousand,**	D+ P
	2_76_1_2	D	**good,**	
	2_76_1_3	D	**we can wait for ( ) um 1592,**	
	2_76_1_4	D	**at least find what's happening there.**	
	2_77_1_1	P	Mm-hmm.	institution
	2_78_1_1	D	If not	**D alone**
	2_78_1_2	D	**[[what I'll do]] is [[probably stop the nevirapine**	
	2_78_1_3	D	**and switch you over to a cousin drug called delavirdine]].**	
	2_80_1_1	D	So I think that's another one [[where we apply to the drug company	
	2_80_1_2	D	and they supply it here]]	
	2_80_1_3	D	but we'll keep the nevirapine going	
	2_80_1_4	D	till the delavirdine arrives.	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: describe/ identify Rx	2_81_1_1	P	Nevirapine, which one's that - the blue one or the white one?	-> D
	2_82_1_1	D	I don't know. (laughs))	
	2_83_1_1	P	It doesn't matter.	
	2_84_1_1	D	It's the one twice a day two hundred milligrams.	
	2_85_1_1	P	That's the white one.	
	2_86_1_1	D	It's now in a little jar.	
	2_87_1_1	P	It's the white one.	
	2_88_1_1	D	Right.	
	2_89_1_1	P	Yes this is um ( )	
	2_90_1_1	D	That's it, ah yeah.	
	2_91_1_1	P	That's the other one.	
	2_92_1_1	D	( )	
	2_93_1_1	P	Three times a day.	
	2_93_2_1	P	.. Oh do I, look when I get it ..	
	2_93_2_2	P	which one are we stopping the nevirapine?	P+
PROPOSE: defer decision	**2_94_1_1**	**D**	**May stop**	
	2_94_1_2	**D**	**yes.**	
PROPOSE: describe treatments	2_95_1_1	P	May, nevirapine?	
	2_96_1_1	D	Yes.	
	2_97_1_1	P	And change it for?	
	2_98_1_1	D	Delavirdine.	
	2_98_2_1	D	Yeah these are the white ones.	
	2_99_1_1	P	Yeah.	
	2_100_1_1	D	Nine point three by nineteen point one millimetre.	
	2_101_1_1	P	((laughs))	
	2_102_1_1	D	( )	
PROPOSE: specify preference	2_103_1_1	P	I just want to || get rid of these horrible blue things,	P
	2_103_1_2	P	because they're vile [[to swallow]].	
	2_103_2_1	P	( ) it's all right.	
PROPOSE: evaluate alternatives/ side-effects: defer description	2_104_1_1	D	Any moisture	
	2_104_1_2	D	basically they just clag up	
	2_105_1_1	P	They do.	
	2_105_2_1	P	I mean as soon as you put it in your mouth	
	2_105_2_2	P	mean it just the moisture is zapped.	
	2_106_1_1	D	Yeah.	
	2_107_1_1	P	It's ghastly.	
	2_107_2_1	P	So is there any side effects with this delavirdine?	-> D
	2_108_1_1	D	Yes.	
	2_109_1_1	P	What?	
	2_110_1_1	D	I'll have to check.	D
	2_111_1_1	P	Okay.	
	2_111_2_1	P	I'm terrified now with drugs.	drugs
	2_112_1_1	D	What they do to you and what may happen.	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: observe, evaluate side effects	2_113_1_1	P	How's my face?	-> D
	2_113_2_1	D	Your right still looks a little bit sunken but very very slight.	
	2_114_1_1	D	Your left actually looking a lot better and I think maybe quite normal.	
	2_114_2_1	D	Your right still looks a little bit sunken but very very slight.	
	2_115_1_1	P	It's not bad is it?	
	2_116_1_1	D	No.	
	2_117_1_1	P	It's getting better.	
	2_117_2_1	P	I mean after you told me	D
	2_117_2_2	P	that it may not come back at all	
	2_117_2_3	P	because it's been so long.	
	2_118_1_1	D	Yeah.	
	2_119_1_1	P	I just willed it back, I just.	P
	2_120_2_1	D	But at the same time you seem to be willing back the mole.	
	2_120_3_1	D	Or the (haemangioma) .	
	2_120_4_1	D	That's getting a little bit darker.	
	2_121_1_1	P	Is it?	
	2_122_1_1	D	Yeah.	
BEARINGS: values calibration	2_122_2_1	D	So have you seen them yet about laser?	
	2_123_1_1	P	No I haven't	
BEARINGS: values calibration	2_123_1_2	P	but I I will.	
	2_123_2_1	P	That's not a priority	
	2_123_2_2	P	I mean I only I wouldn't worry about it Martin [[to be honest]]	P
	2_123_2_3	P	except that it just makes this more noticeable.	mole
	2_124_1_1	D	Yes.	
	2_125_1_1	P	Because it	
	2_126_1_1	D	It draws	
	2_127_1_1	P	It draws attention to that,	mole
	2_127_1_2	P	so without that it would be less noticeable.	
	2_128_1_1	D	Yeah.	
	2_129_1_1	P	You know.	
	2_129_2_1	P	So that's the only reason	
	2_129_2_2	P	just in case it ever happens again	
	2_129_2_3	P	which <<God forbid>> I don't want to.	
PROPOSE: declare/ ENUNCIATE	2_130_1_1	D	Soon as it does	
	2_130_1_2	D	we'll stop whatever drug.	D+ (P)
ENUNCIATE Prevaricate	2_131_1_1	P	Yeah but we did that last time.	
	2_131_2_1	P	But I mean it's taken-	D+P
AMPLIFY:	2_132_1_1	D	Well we've got to get the drug going along for a couple of extra months so	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
values calibration	2_133_1_1	P	Pretty dra- well I mean well I was just unlucky.	
	2_134_1_1	D	Yes.	
	2_135_1_1	P	Lot of people have got a lot worse side effects than me.	
	2_136_1_1	D	And lots of people have none so.	
	2_137_1_1	P	Yeah that's right y'know so	
	2_137_1_2	P	but does make you a bit more apprehensive than	it = experienc e?
	2_138_1_1	D	( )	
MARKERS: lab results: offer/ demand results	2_139_1_1	P	That well may happen yeah	
	2_139_1_2	P	so what what what were my T cells last time?	

The excerpt above covers the review of the effectiveness of the patient's current drug regimen. By the end of consultation 2, it has been established that:

- Philip's viral load is 30,000.
- Philip feels well, and does not feel many side effects from the regimen.
- Philip is not "concerned" about the results.
- Martin's "cut-off" for viral load is 10,000.
- Thus for the current regiment o be maintained, the next viral load result will need to be less than 10,000.
- If the next results are less than 10,000 Philip will stay on the current regimen until the opportunity to be involved in the 1592 clinical trial has been explored.
- If the next results are not less than 10,000 it will be unwise to wait (it is not clear how long) for the trial, and the current regimen should be modified by changing nevirapine to delavirdine.

Table 6.13 Extract from Consultation 3: Martin and Philip

GSP phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: Motivate visit	3_12_1_1	D	Exactly.	
	3_12_2_1	D	All right now what can I do for you?	D
	3_13_1_1	P	Viral load. ((laughs))	
	3_14_1_1	D	Okay.	
MARKERS: lab results	3_15_1_1	P	And I don't suppose, no the result from las-	
BEARINGS: Update since last visit	3_16_1_1	D	Did the last one come through?	
	3_17_1_1	P	Last week we had it done.	P+D
	3_17_2_1	P	Did it Monday	
	3_17_2_2	P	and you said	D
	3_17_2_3	P	come Thursday	
	3_17_2_4	P	and you should have the result. ((laughs))	
	3_18_1_1	D	Oohh.	
	3_18_2_1	D	Sorry I'm (P: Not with it , confused).	
	3_19_1_1	P	Not with it , confused.	
	3_20_1_1	D	I thought	D/ notes
	3_20_1_2	D	I'd discussed these with you from [[what I'd written in the notes]].	
	3_20_1_3	D	[[what I'd written in the notes]].	
	3_20_2_1	D	So I'll[	
	3_21_1_1	P	They're from the sixteenth of June.	
	3_22_1_1	D	Yes yeah.	
MARKERS: lab results: offer/demand results	3_23_1_1	P	Is it dreadful?	
MARKERS: deliver results	3_24_1_1	D	Ah, mm, no	
MARKERS: deliver results	3_24_1_2	D	just not as good as it could be.	
MARKERS: deliver results	3_24_2_1	D	.. Okay <<going through it>> [[what we've got]] is [[March, April and then June your T-cell percentage has been roughly the same]].	D+P / notes
MARKERS: deliver results	3_24_3_1	D	Fifteen.	
	3_25_1_1	P	Eleven.	
	3_26_1_1	D	Eleven, twelve.	
	3_27_1_1	P	So it's twelve now.	
	3_28_1_1	D	Yeah.	
MARKERS: evaluate results	3_29_1_1	P	So what does that represent, about how many?	percentage
	3_30_1_1	D	You're looking at the two hundred to two hundred and fifty range.	
MARKERS: situate results	3_31_1_1	P	Okay it's about [[what I've always been]] hasn't it?	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	3_32_1_1	D	Yeah so it hasn't changed.	
	3_33_1_1	P	Mm-hmm.	
	3_34_1_1	D	Ah now the viral load back in March four thousand one hundred.	
	3_35_1_1	P	Mm-hmm.	
	3_36_1_1	D	Then three thousand nine hundred	
	3_36_1_2	D	which is much the same.	
	3_36_2_1	D	This time around ten thousand one hundred.	
	3_37_1_1	P	Mm-hmm.	
	3_39_1_1	P	Mm-hmm	
	3_40_1_1	D	Now .	
	3_41_1_1	P	Then it's come down then.	
	3_42_1_1	D	No it's gone from three thousand to	
	3_43_1_1	P	No but I had er in the =	
	3_44_1_1	D	Oh the original	
	3_45_1_1	P	On the nineteenth of May I was up to twenty-five thousand in between that	
	3_45_1_2	P	which you don't have the result for	
	3_46_1_1	D	Ooh	
	3_47_1_1	P	which was done at the hospital.	
	3_48_1_1	D	Okay I'm totally confused.	
	3_48_2_1	D	That doesn't make any sense.	that = account?
	3_49_1_1	P	Well,	
	3_50_1_1	D	Did anything else happen.	
	3_51_1_1	P	Not really	
	3_51_1_2	P	because you put me on DDC	D
	3_51_1_3	P	after I got that twenty-five thousand five hundred result	
MARKERS evaluate results	3_51_1_4	P	so maybe that is working.	
	3_52_1_1	D	Right.	
	3_54_1_1	D	Yep.	
	3_55_1_1	P	Little bit.	
	3_56_1_1	D	So	
	3_57_1_1	P	And now you're not totally confused?	
MARKERS situated results	3_58_1_1	D	Was the time difference just a fortnight?	
	3_59_1_1	P	I could, I started the, no three weeks.	
	3_60_1_1	D	Three weeks, okay good.	
	3_61_1_1	P	Twenty seventh of May I started the drug	
	3_61_1_2	P	and it was on the sixteenth of June.	
	3_62_1_1	D	Right. Right.	
MARKERS: evaluate results	3_63_1_1	P	So it's good results. ((laughs))	
	3_64_1_1	D	Yes it is.	
	3_64_2_1	D	All right,	
	3_65_1_1	P	Just what I need.	
	3_66_1_1	D	And	
Parallel	3_67_1_1	P	I like that colour on you Martin,	P

GSP phase	Clause ID	Spkr	Text	Semiotic agent
context; non-medical frame	3_67_1_2	P	it's really nice. ((laughs))	
MARKERS: evaluate results	3_68_2_1	D	((laughs)) Um hopefully we can get this down a fraction more.	
	3_69_1_1	P	Okay.	
RECAP: recap decision/enactment plan	3_70_1_1	D	And I discussed with you last time [[stopping the nevirapine]],	D
	3_71_1_1	P	Yeah.	
	3_72_1_2	D	going on to delavirdine and everything else.	
	3_73_1_1	P	Yeah, right.	
	3_74_1_1		[[What I'd rather do]] is [[wait || till we find about the fifteen ninety program]].	
	3_75_1_1		Okay	D+
	3_76_1_1	D	If you're eligible,	
	3_76_1_2	D	if you're lucky in the lottery,	
	3_76_1_3	D	we'll put you on that	
	3_76_1_4	D	and see what response [[you get from that]].	
	3_76_2_1	D	If you don't get into the fifteen ninety two	
	3_76_2_2	D	then we'll start	
	3_77_1_1	P	Juggling around	
	3_78_1_1	D	Swapping everything else around.	
MARKERS evaluate results	3_79_1_1	P	So it's still so that's quite a load.	->D
	3_80_1_1	D	Yeah well ten thousand is my cut off	
	3_81_1_1	P	Yeah	
	3_82_1_1	D	If we can get it within the ten thousand	
	3_83_1_1	P	Well I'm only one thousand off that	
	3_86_1_1	D	Yeah	
	3_87_1_1	P	Which is	
	3_87_1_2	P	**so I'm on your cut off. ((laughs)) (D: Yeah). Aren't I?**	-> D
	3_88_1_1	D	**Yeah**	
	3_89_1_1	P	**Aren't I?**	
	3_89_2_1	P	**Well that's good.**	
	3_90_1_1	D	**Yep**	
AMPLIFY	3_91_1_1	P	**Because I'm gonna have my surgery on Tuesday. ((laughs))**	
	3_92_1_1	D	**Right great**	
	3_92_1_1	D	Right great	
	3_93_1_1	P	Well they scheduled it	
	3_93_1_2	P	so I just thought, well I think	P
	3_93_1_3	P	I was a being bit of a drama queen.. in the beginning.	
	3_94_1_1	D	Mm-hmm	
	3_95_1_1	P	And it's got to be such a minor operation for goodness sake. Hasn't it?	
	3_95_1_2	P	It's only a patch job	
	3_95_1_3	P	I mean it's not like they're removing anything	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	3_96_1_1	D	Yeah.	
	3_96_2_1	D	They (can sew in over the) hole with some material and	
	3_97_1_1	P	Yeah	
	3_98_1_1	D	Stitch you up.	
PROPOSE: elicit recommendation	3_99_1_1	P	So do you think it's a good idea?	-> D' P
	3_100_1_1	D	It'll make you happy.	
	3_101_1_1	P	((laughs))	
	3_102_1_1	D	But you've been asking everyone around it	
	3_103_1_1	P	Yeah	
	3_104_1_1	D	About about it for a month?	
	3_105_1_1	P	Yeah	
	3_106_1_1	D	So	
	3_107_1_1	P	Get it over and done with	
	3_108_1_1	D	Yeah	
	3_109_1_1	P	Well I just wanted to find out if it's purely cosmetic	P
	3_109_1_2	P	'cause if it is	
	3_109_1_3	P	and I can live with it	
	3_109_1_4	P	if I don't like it	
	3_109_1_5	P	but I'm ( )	
	3_109_1_6	P	and I lived with that you know	
	3_110_1_1	D	Mm-hmm	
	3_111_1_1	P	So but I told you	
	3_111_1_2	P	I asked the um the treatment room doctor	
	3_111_1_3	P	to speak to well she offered	treatment room doctor
	3_111_1_4	P	to speak to the surgeon[	
	3_112_1_1	D	surgeon]	
	3_113_1_1	P	She knows him and that.	
	3_114_1_1	D	Yeah	
	3_115_1_1	P	And um just to make sure	
	3_115_1_2	P	that he wasn't just doing it	
	3_115_1_3	P	because you know he could sort of thing	
	3_115_1_4	P	and he did say	surgeon
	3_115_1_5	P	that it wasn't urgent	
	3_115_1_6	P	that you know if I wanted to go away	surgeon" P
	3_115_1_7	P	and have a holiday whatever	
	3_115_1_8	P	would certainly be all right [[to leave for a few more few more months]]	
	3_115_1_9	P	and he didn't think	surgeon
	3_116_1_1	D	Yeah	
	3_117_1_1	P	Declorupture wherever the blood supply can cut off	
	3_118_1_1	D	Yeah	
	3_119_1_1	P	Umm that was was unlikely	
	3_120_1_1	D	Mm-hmm	
	3_121_1_1	P	But he did feel	
	3_121_1_2	P	that it would get bigger with time	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	3_121_1_3	P	and that it would need doing eventually	
	3_122_1_1	D	Right	
	3_123_1_1	P	And that while I 'm well,	
	3_123_1_2	P	it's certainly the best time	
	3_124_1_1	D	While it's small	
	3_125_1_1	P	And while it's small	
	3_125_1_2	P	because it's easier to repair. So	
	3_126_1_1	D	So what in hospital[	
	3_127_1_1	P	with that information]	
	3_128_1_1	D	on Tuesday	
	3_129_1_1	P	No surgery on Tuesday	
	3_129_1_2	P	they wanted me to go in on Friday, tomorrow	hospital
	3_130_1_1	D	Right	
	3_131_1_1	P	and I said I want to go to play on the weekend.	P" P
	3_131_2_1	P	((laugh)) I don't want to be in hospital all those bloomin days before	
	3_132_1_1	D	Yep	
	3_133_1_1	P	You know.	
	3_133_2_1	P	So Sue very kindly arranged	Sue
	3_133_2_2	P	she spoke to the haematologist	
	3_133_2_3	P	and they've taken me off warfarin as of Tuesday night.	
	3_133_2_4	P	So my last dose of warfarin was Monday	
	3_134_1_1	D	Right so you're back onto the fragman?	
	3_135_1_1	P	Ah nothing.	
	3_135_2_1	P	I've just been to the hospital	
	3_135_2_2	P	and had an INR umm	
	3_135_2_3	P	I was goin' to have it here	
	3_135_2_4	P	but I don't know	
	3_135_2_5	P	whenever they take blood	
	3_135_2_6	P	they always put it on ice	
	3_135_2_7	P	and then they take it to the lab.	
	3_135_3_1	P	Because otherwise the hema something or other	
	3_136_1_1	D	Yeah you do get a more accurate result that way	
	3_137_1_1	P	Yeah so I thought	P
	3_137_1_2	P	well being as it's important	
	3_138_1_1	D	More critical]	
	3_139_1_1	P	yeah that it's best [[it's not lying around here for two or three hours ||before it goes to the lab]].	
	3_139_2_1	P	So I've already been down there	
	3_139_2_2	P	and had that done um this morning	
	3_139_2_3	P	and um they're go-- once it goes down to one point three	
	3_139_2_4	P	they're going to put me on clexsan intravenously simultaneously rather	
	3_183_1_1	P	What are you going to do now?	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
BEARINGS: check agenda	3_184_1_1	D	A viral load	
	3_185_1_1	P	Again? We just	
	3_186_1_1	D	Didn't you say you wanted one	P
	3_187_1_1	P	No we just	
	3_188_1_1	D	Oh you wanted to discuss it	P
	3_189_1_1	P	((laugh))	
	3_190_1_1	D	Oh sorry	
AMPLIFY	3_191_1_1	P	Martin, what's wrong with you lately? ((laughs))	
	3_191_1_2	P	You in love or something?	
	3_192_1_1	D	I wish	
	3_193_1_1	P	You've been away with the pixies for about the last three four weeks ((laughs))	
	3_194_1_1	D	( )	
	3_195_1_1	P	Normally you're so on the ball	
	3_195_1_2	P	I mean I'm amazed sometimes at how you can remember [[like what drugs I'm taking and this and this]] but	D (at risk)
	3_196_1_1	D	Yep	
	3_197_1_1	P	But you're totally I mean you	
	3_197_1_2	P	last time we spoke	
	3_197_1_3	P	you still thought	
	3_197_1_4	P	I was on the same medication [[that I was on a	
	3_198_1_1	d	eighteen months ago]	
	3_199_1_1	P	year ago ((laughs)).	
	3_200_1_1	D	Okay I think I'll sit down and read your notes	
	3_200_1_2	D	before I go to bed at night	
	3_200_1_3	D	and remind myself of this	
	3_201_1_1	P	Oh it doesn't matter	P
	3_201_1_2	P	'cause I remember	
	3_201_1_3	P	so . . doesn't matter	
BEARINGS Propose/check agenda	3_202_1_1	D	It's just that the notes I write, last time it actually looks [[as if I've given you the results]]	notes
	3_203_1_1	P	Oh right	
	3_204_1_1	D	Rather than I've bled you.	
	3_205_1_1	P	Right	
	3_206_1_1	D	So when you said viral load I presumed	notes " P
	3_207_1_1	P	Right	
	3_208_1_1	D	You wanted another one	
	3_209_1_1	P	No. No.	
	3_210_1_1	D	Right	
??	3_211_1_1	P	I mean I just want to get some	P
PROPOSE Rx: declare/ ENUNCIATE	3_212_1_1	D	**Yeah so look stick with the ddC**	D
	3_212_1_2	D	**it is working,**	
	3_212_1_3	D	**it's doing the right thing**	
PROPOSE: evaluate options	3_213_1_1	P	Now does that drug have any side effects um relating to the bladder?	-> D
	3_214_1_1	D	No.	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	3_215_1_1	P	Couldn't possibly?	
	3_215_2_1	P	'Cause I'm sure	P
	3_215_2_2	P	when I took it before	
	3_215_2_3	P	I started to have bladder problems	
	3_215_2_4	P	and they seem and [	
	3_216_1_1	D	starting to come back]	
	3_217_1_1	P	they're um I mean I even went into hospital	
	3_217_1_2	P	and had a bloomin' cystoscopy and all that nonsense	
	3_217_1_3	P	and then did a nick and a tuck and all this business	
	3_217_1_4	P	and still my bladder was a nightmare for year literally years	
	3_217_1_5	P	and it's only just sort of a few months ago [[that it started to come back right]] and now it seems to be playing up a little bit again.	
	3_218_1_1	D	Well maybe it is	
	3_219_1_1	P	Yeah. . I mean it's not bad at the moment	
	3_219_1_2	P	I mean nowhere near like it was	
	3_219_1_3	P	but I'm just wondering	P
	3_219_1_4	P	if you know using the drug over a long term	
	3_219_1_5	P	but I don't think I took it for that long before.	
	3_220_1_1	D	Yeah I have it written down.	D + notes
	3_220_2_1	D	You started in march ninety five.	
DECLARE recommend-ation	3_220_3_1	D	Um well what we can do is [[wait...]]	P
	3_220_3_2	D	[[wait till your after your surgery	
	3_220_3_3	D	and if you'd like	
	3_220_3_4	D	switch you over to the DDI	
	3_220_3_5	D	and just see what happens to your bladder]].	D (+P?)
	3_221_1_1	P	Mm	
	3_222_1_1	D	After that.	
	3_222_2_1	D	See if it is related to the drug.	
AMPLIFY/ prevaricate	3_223_1_1	P	Hmm. Don't know which is worse	P
	3_223_1_2	P	every day sort of having to work around	
	3_224_1_1	D	Yeah eating around the pill	P + D
	3_225_1_1	P	food having or having a dodgy bladder	

By the end of Consultation 3 between Martin and Philip, the following situation has been established.

- The patient's current viral load is 10,100.
- This is a drop from 25,500.
- This probably means the drugs are working.
- 10,100 may be a 'good result' but it still indicates a change of treatments should be undertaken.
- This change of treatments can wait a number of weeks in order to (possibly) participate in the 1592 trial.
- The ddC may be causing side effects so it is agreed to change to ddI after the patient's imminent surgery.

This shared plan of action is not, however, easily established. It involves considerable confusion, requiring considerable negotiation of fact and perspective, and considerable reiteration of consultation phases. It also involves the patient drawing on a range of resources to achieve such reframings. These resources include the manipulation of conventional question-and-answer mode of interaction in medical discourse, in which the patient positions the doctor as the primary knower with regard to potential side effects. This "sequential mode" is developed into a narrative mode by the patient (Stivers and Heritage 2001) through which he presents his experience with this putative side effect. By sequencing this narrative after getting the doctor to declare his understanding that there are no side effects of ddC on the bladder, the patient uses the narrative function as a challenge to this established wisdom.

In terms of agency and shared decision-making, we can observe that Philip is, by this method, able to engage collaboratively in clinical reasoning. His perspective on ddC's likely side effects is taken into account and a new treatment recommendation made by the doctor (at turn 220). Notably, Martin modalises this particular treatment recommendation, presenting it as suggestion: "*What we <u>can</u> do is wait till after your surgery ...*". At the same time, the patient is *activated* textually as a *desiderative agent*, in whose view the treatment recommendation – and the treatment itself – is contingent: "if you'd like, switch you over to the ddI". This way of realizing the

generic move of *declaration* contrasts with Martin's typical pattern of realizing this move using a temporal finite (such as "What we will do is.."). At the grammatical level of description, these differences occur largely within the interpersonal resources, but they clearly also have effects at a semantic level on how the patient is represented. In the typical realization pattern, the patient is only made *visible,* rather ambiguously, through possible inclusion in the plural first person, as an *undifferentiated actor* with respect to the doctor, and in cases in which the process of deliberation is *suppressed.*[1]

Arguably in this case, the doctor's representation of the patient as agentive with regard to treatment decision-making is in an important way a response to the patient's immediately prior enactment of clinical reasoning (Linell 1990). This episode can be read as a microcosm of the role of patient report of problems and successes in the institutional establishment of treatment (and prevention) policies in HIV. In other words, it is a local instantiation of a dialectic between structure and agency in which the person living with HIV is sometimes able to influence the structures which shape the choices available to them.

But this is not always the case, and other perspectives from this patient are either not taken up, or acknowledged in order to be dismissed by this doctor (cf. Maynard 1991). As discussed in relation to Consultation 1, Martin and Philip's representation of each other in terms of their respective agentive roles is often out of alignment. Arguably Martin and Philip are also out of alignment with respect to the how they believe the discourses of health experience, health care and health measurement should be prioritised in determining treatment choices. Perhaps surprisingly, this is particularly the case in Consultation 2, where there is a considerable *display* of alignment.

As the extract from Consultation 2 begins, the doctor is taking blood for a fresh viral load test ("*I'll just finish this...*") and says he'll look up the patient's old viral

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[1] Within SFL, Hasan has discussed similar kinds of differences in ways of realizing offers. Her (1994) distinction between assertive and consultative offers could be used to describe doctor Martin's typical style of treatment recommendation and his atypical instance at turn 220 in Consultation 3. But, in medical interaction at least, the distinction between offers and commands is highly ambiguous. Some analysis of these issues has been done on the present data, with particular reference to shifting discourses of compliance and adherence (Candlin et al. 1998).

load (turn 54), thus *activating* himself with respect to holding and distributing information about the patient's health as well as with regard to agenda-setting in the consultation, and *backgrounding* the patient's role and the role of other parties. The patient knows his viral load, and responds by offering this information (turn 55), followed by an elaboration of his routine of keeping a record of his results (turn 58), in which the patient *activates* himself in the role of additional, *differentiated* knower and manager – this role is reprised in Consultation 3 when the patient offers himself as a kind of 'backstop' semiotic agent to the doctor ("it doesn't matter because I remember"). The viral load result in Consultation 2 is quite high, and the patient might be expected to pursue a discussion of what this means in terms of cause (e.g., the likelihood of it being due to skipping doses, or how easy it might be to get it down), but instead he dismisses the importance of the result by contrasting it with, and ascribing primary importance to, a subjective sense of wellbeing: "*But I feel all right so y'know that's the main thing, isn't it*" (turn 60). In line 8, the contrastive ("but") and the patient's self ("I") form the grammatical Theme of the first clause, and this sets up a strong opposition between the discourses of health measurement and health experience. The evaluative equative in clause 2_60_1_2 ("*that's the main thing*") presents the patient's privileging of health experience over health measurement.

Unlike the Consultation 1 and Consultation 3, there is no dispute of fact in the discussion of viral load and treatment plans in Consultation 2, and nor, on the face of it, is there any dispute of interpretation between the doctor and the patient, who appear to be cordially co-constructing a joint position based on the patient's offering in turn 60. The doctor responds favourably: "Yes, that's halfway there" (turn 61). The patient returns with a similar pattern: "Yeah. Well this is only part of the picture isn't it?" (turn 62). A further series of moves explores, hypothetically, how they would trade off subjective ill health against good objective results, and a benchmark of acceptability for the next viral load result is established, all in a context of collaboration and agreement. This context is created by explicit tokens of agreement ("yeah", "mm", "exactly"); tokens of appraisal (Martin 2000a); positive confirmations in response to tag questions; interpersonally and experientially similar idioms or tropes (D: "*half way there*"; P: "*part of the picture*"); repetition of each

other's lexis ("*feeling lousy*" in turns 64 and 65); highly symmetrical turns in terms of length and speech function; even collaborative completion of turns (Lerner 1996, Jacoby and Ochs 1995).

However, if we look more closely we see that these two are not jointly constructing/activating the same discourse, even if they are in some sense constructing a joint position and genuinely agree on not changing the drugs at this point as well as on what to hope for from the next result. The patient and the doctor have potentially conflicting priorities, illustrated below, which arise out of their differential privileging of health discourses. Four possible basic (idealised) situations are represented in the four cells of Table 6.14, namely (i) feeling good and viral load down; (ii) feeling good and viral load up; (iii) feeling lousy and viral load down; (iv) feeling lousy and viral load up. There are several ways in which people might value these situations as outcomes in terms of treatment, and these can be represented by four points on an ordinal scale of priority. The values of Martin and Philip, according to what they say in this consultation, are represented in Table 6.14 below.

Table 6.14 Patient's (P) and Doctor's (D) prioritisation of health outcomes as alignment of discourses, Consultation 2: Martin and Philip

HEALTH MEASUREMENT	HEALTH EXPERIENCE	
	feeling good	*feeling lousy*
viral load down	1st	2nd (D)
viral load up	2nd (P)	4th

It would be very surprising if the doctor and patient did not share views on the best scenario (low viral load + feeling good), marked "1st" in the table, and on the worst scenario (high viral load, feeling lousy) marked "4th". Regarding the other possible outcomes, the doctor and patient's alignment is at best vague. In my data the patient indicates where his priorities lie: he would prefer to have a high viral load and feel well than to have a low viral load and feel lousy (turns 60 and 64). The doctor is less explicit, but it seems likely from his remarks, and his proposals regarding treatment changes, that he does not share the patient's order of priorities. The doctor says he would want to change the drugs if the patient was feeling lousy, even if the viral load results were "fantastic", but he does not say whether he would condone staying on a regimen the patient felt well on if it had less than optimal effect on viral load. This is best understood as an example of lack of alignment between doctor and patient in terms of discourses generally, rather than merely a one-off difference of opinion.

Notably, this phase of the consultation finishes with the patient following the doctor back into the discourse of health measurement, elaborating the treatment goals and plans entirely in terms of viral load. A practical realization of this misalignment in discursive orientation comes in Consultation 2, when the patient raises a concern about side effects (clause 2_107_2_1) on the doctor's recommendation replacement drug, delavirdine, saying that he is "*terrified now with drugs*" (clause 2_111_2_1) as a result of side effects from earlier treatments. The doctor's response is to reassure the patient that they will stop the drug if that should happen again (turn 2_129). This is not very reassuring for the patient, and he indicates this, but the problem is not resolved by deliberating on different options or by elaborating on the patient's fears and feelings. Rather, the doctor emphasises the need to establish the treatment, the patient responds in "philosophical" manner, offers a downgraded restatement ("terrified" is now "a bit more apprehensive" at turn 137), and then the subject is dropped as the topic shifts to previous T-cell readings. This is a possible example of a potential decision abandoned.

Logogenetically, we can see such misalignment prefigured earlier in the conversation, when the patient says that subjective health is the "main thing" and the doctor calls it "half way there" (clauses 2_60_1_2 and 2_61_2_1). These two idioms have considerable contrastive value. To begin with, the different idioms pick up on

general lexicogrammatical patterns associated with particular discourses of health as described above. By characterising feeling well as "halfway there", the doctor invokes the semantics of goal-oriented action and of progressing towards a better future, meanings which are characteristic of the discourse of health care. This goal-directedness is not present in the patient's choices of idiom, which instead rely on images of static part-whole relations, (e.g., "part of the picture"), and which resonate with the static 'here and now' effect of tense and aspect choices characteristic of the discourse of health experience. On top of this, each of the idioms here functions in a somewhat variable but nonetheless organised system for grading relative value (Martin 2000a). In this system, being the main thing is clearly better than not really being the main thing, being halfway there' is clearly not as good as being 'almost there', and so on. What is not so clear is how these two scales are calibrated against each other; but the doctor's choice to call feeling well "half way there" (turn 61) appears to downgrade it somewhat from being "the main thing", leaving more room for the importance of a low viral load, and moving away from the discourse of health experience that the patient has activated. When the patient responds to this with "this [viral load] is only part of the picture" (turn 62), he is in turn downgrading viral load and, by implication, re-upgrading feeling well, and re-privileging the discourse of health experience.

Diagrammatically, in terms of the areas of meaning potential drawn on by the two interactants, this misalignment is also prefigured in the way in that Martin and Philip, across their consultations, tend not to explicitly explore different viewpoints in ways that require the elaboration of the *other*'s point of view. Instead, Martin and Philip tend to simultaneously represent views and display alignment in a high-solidarity style which positions interactants as already knowing what each other thinks. A comparison of the numbers of Figures of Sensing and Figures of Saying, used in each set of discussions about HAART provides an indicative illustration of this, especially if we consider who is mapped into the role of semiotic agent (senser/ sayer).

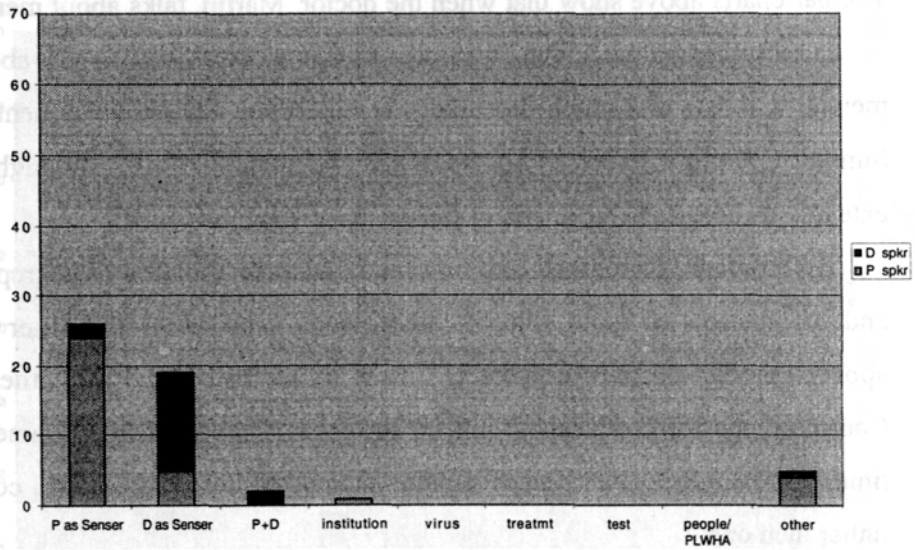

Figure 6.18 Distribution of Senser roles to social and symbolic actors in Consultations 1, 2, and 3 (Martin and Philip), by Speaker

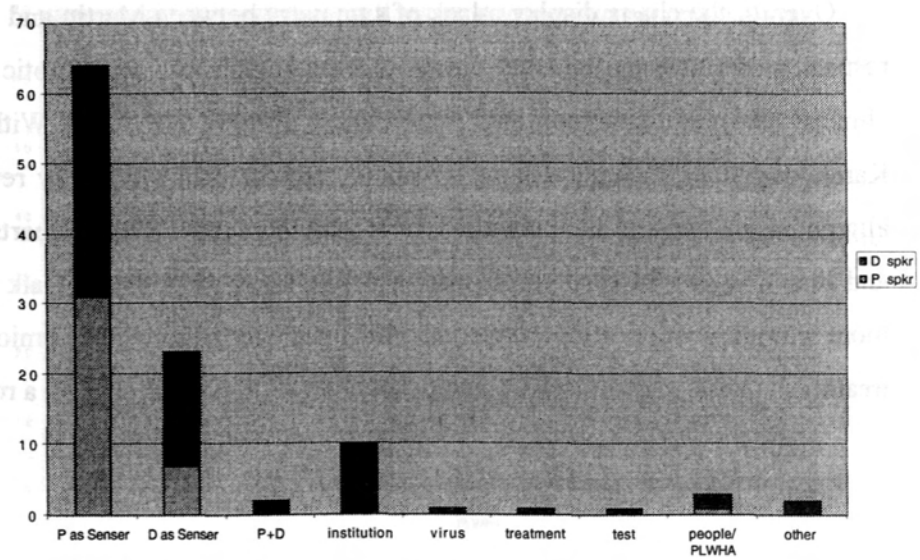

Figure 6.19 Distribution of Senser roles to social and symbolic actors in Consultation 59 (Karen and Joan), by Speaker

The bar charts above show that when the doctor, Martin, talks about mental activity or action (thinking, perceiving, wanting, or feeling), he is likely to talk about his own mental activity, and much less likely to talk about the patient's mental activity. Similarly, Philip is likely to talk about his own mental activity, although to a lesser extent – he construes the doctor as Senser somewhat more often.

By contrast, Karen and Joan are much more reciprocal in their representation and projection of each other's ideas, each construing the other as Senser approximately as often as herself.[12] It is of interest that Philip, the patient in Consultations 1 to 3, represents himself as Senser approximately the same number of times as Joan does, over a much smaller amount of talk, albeit over 3 consultations rather than one.

A similar comparison is seen in the distribution of Figures of Saying, as shown in Figures 6.20 and 6.21 below. Taking into account the smaller amount of talk between Martin and Philip, again, the patient's representation of himself, and of the doctor, in the role of Sayer is rather high, but the doctor, Martin, rarely construes Philip as a Sayer, just as he rarely construes Philip as a Senser.

Overall, the charts display a lack of symmetry between Martin and Philip with respect to the two participants' views of the patient's role as semiotic agent – as clinical reasoner, deliberator, preference holder, decider, and so on. With respect to Karen and Joan, the charts show a visual symmetry which arguably reflects more alignment in views of the patient's role as semiotic agent. The bar charts for Karen and Joan (Figures 6.19 and 6.21) also visually display the way their talk construes a more complex world of distributed and mediated agency in which semiotic objects, treatments, tests, parts of selves, and differentiated individuals all play a role.

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[1] I have compared one consultation from Karen and Joan with the three consultations between Martin and Philip in order to keep amount of talk reasonably close, although there is no obvious way of "controlling" for length: taking just a certain number of clauses, and taking proportions each introduce their own particular bias in discourse research. The total number of clauses represented in the figures for Martin and Philip is 243; for Karen and Joan the total number of clauses represented is 459.

[2] For a number of reasons I have not focussed on comparing the distribution of such grammatical/ semantic choices but future work will focus on these aspects and their elaboration.

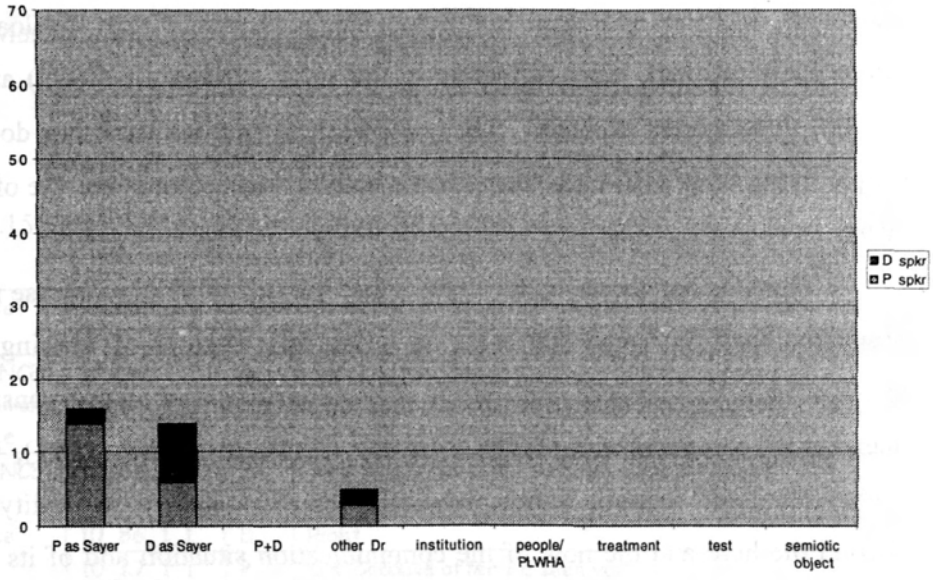

Figure 6.20 Distribution of Sayer roles to social and symbolic actors in Consultations 1, 2, and 3 (Martin and Philip), by Speaker

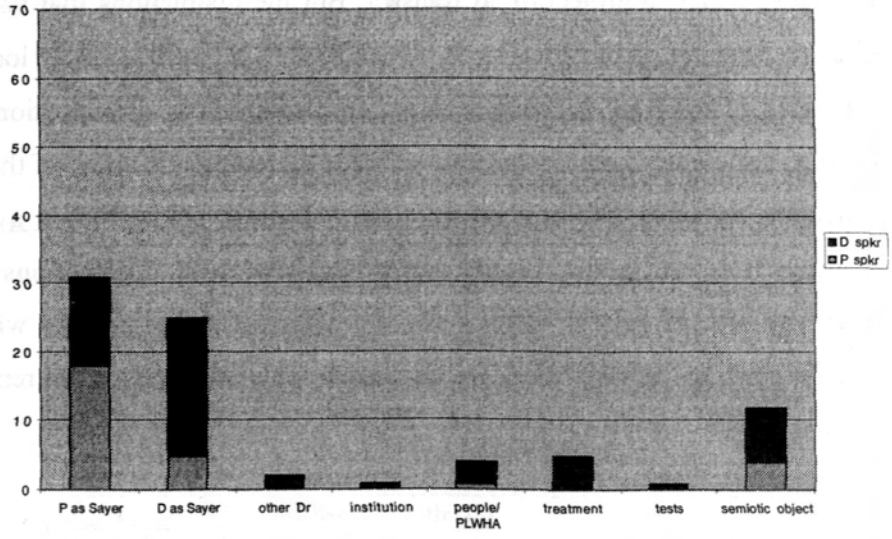

Figure 6.21 Distribution of Senser roles to social and symbolic actors in Consultation 59 (Karen and Joan), by Speaker

In particular, Karen and Joan's discourse *activates* semiotic objects, including arguments, decisions and ideas. In this way the discourse of Karen and Joan is more semiotically abstract, more reflective in the sense of Hasan's (1999) and Butt's (2000b) descriptions of Field. They activate and personalise other doctors and people living with HIV, even the patient's body is mapped into the role of semiotic agent.

What the bar charts do not show is that Martin and Philip also use much less projection than do Karen and Joan: as a rule their Figures of Sensing construe relations between speakers and speech as macrophenomenal and responsive rather than metaphenomenal and creative. In van Leeuwen's terms (1995), this is to "behaviouralise" semiotic action, which is then "divested of its ability to reach beyond the here and the now of the communication situation and of its ability to represent the 'then and the there' to take into account what is elsewhere, to remember the past, to imagine the future". Van Leeuwen's position is more extreme than that taken in the present thesis – he provides for semiotic action which is treated linguistically either as semiosis, or as behaviour, and parallels these categories with the ability *either* to project *or* to transact. But the distinctions that van Leeuwen relies on here are grammatical ones, which tend to be reflected only loosely in the semantics of medical decision-making. Projected ideas and locutions can also transact, and non-projecting types of semiotic action can do some of the work that projection provides for, in creating a new semiotic object that is available for scrutiny. It is crucial to identify when and how such distinctions are made, especially with respect to establishing a discursive environment in which shared decision-making can take place. This issue will explored further in the remaining two sections.

6.5.2 Unilateral decision-making with shared review

If we view treatment decision-making as a cycle involving initiation and ongoing review, one implication is that we must consider the way in which that cycle can take place partly "offstage", including occasions where unilateral decisions to treat or stop

treating are made by the patient outside the clinical setting. Consultation 10, between doctor Martin and patient Stephen, involves such a case.

Table 6.15 Extract 1 from Consultation 10: Martin and Stephen

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
ADHERENCE: offer/demand adherence	10_84_3_1	D	And, and how are you going with the saquinavir,	
	10_84_3_2	D	with .. [[taking it with the grapefruit juice or the food or whatever?]]	
ADHERENCE: report adherence	10_85_1_1	P	Well this is [[where I've been a naughty boy]] . ((laughs))	
	10_86_1_1	D	Right.	
	10_87_1_1	P	Um, because after I'd seen you,	
	10_87_1_2	P	a lot of questions came in my mind	? questions
	10_87_1_3	P	and then a friend of mine rang up,	friend
	10_87_1_4	P	to reassure me	
	10_87_1_5	P	that um, that <<because i-i- his um viral load had dropped from a hundred and twenty nine thousand to seven hundred and something or other>>, ah that there was hope for me.	
	10_88_1_1	D	It was worth persisting.	
	10_88_1_2	D	Yeah.	
	10_89_1_1	P	Yeah, and I said,	P
	10_89_1_2	P	oh, how are you going with the grapefruit juice?	
	10_89_2_1	P	And he said	friend
	10_89_2_2	P	I'm not on grapefruit juice, I'm on Zantac.	
	10_90_1_1	D	Right, yes.	
AMPLIFY shared technical code	10_91_1_1	P	And I- so thought	P
	10_91_1_2	P	I would query this.	
	10_91_2_1	P	Um I had to go and have my feet looked at, at the Harrington Street Clinic,	clinic/ regimen
	10_91_2_2	P	and I queried it there,	P
	10_91_2_3	P	but was told	clinic
	10_91_2_4	P	that I should be on BOTH things.	
	10_91_2_5	P	I mean	P'-> D
	10_92_1_1	D	[((heavy breathing))	
	10_93_1_1	P	that might be contrary] to what you, [[what you think]] ((small laugh)).	
	10_94_1_1	D	Yeah.	D
	10_95_1_1	P	.... And=	
	10_96_1_1	D	=It's overkill ((small laugh)).	
	10_97_1_1	P	Right, right	
	10_98_1_1	D	I think, ...	D" D
	10_98_1_2	D	one or the other.	
	10_99_1_1	P	Fine.=	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	10_100_1_1	D	=If you can do both,	
	10_100_1_2	D	great.	
DECLARE recommendation	10_100_2_1	D	Ah, but my philosophy is [[start with the grapefruit juice]];	
	10_101_1_1	P	Yes	
AMPLIFY shared technical code	10_102_1_1	D	it's cheap,	
	10_102_1_2	D	it's easy,	
	10_102_1_3	D	and you're not taking another pill.	
	10_103_1_1	P	.. Right.	
	10_104_1_1	D	But for people that REALLY can't cope with it,	
	10_104_1_2	D	don't like the taste,	
	10_104_1_3	D	or it gives them diarrhoea or an upset stomach or something like that,	
	10_104_1_4	D	then I generally say to them,	
	10_104_1_5	D	look forget the grapefruit juice;	
	10_104_1_6	D	give Zantac a go.	
	10_105_1_1	P	Right.	
	10_106_1_1	D	And .. do it that way.	
	10_107_1_1	P	Well wh- what my problem was	? clinic
	10_107_1_2	P	that ah ah I- I was told	
	10_107_1_3	P	that you're supposed to have another bit of it an hour [[after you- you take the first ah lot of ah grapefruit juice]]	
	10_108_1_1	D	Oh, have grapefruit juice=	
	10_109_1_1	P	=Juice	
	10_110_1_1	D	have your saquinavir,	
	10_110_1_2	D	and grapefruit juice an hour later?	
	10_111_1_1	P	Ah, later,	
	10_111_1_2	P	and it just to me was problematic	P
	10_112_1_1	D	No.	
	10_113_1_1	P	at work et cetera, ah	
	10_114_1_1	D	No.	
	10_115_1_1	P	Yeah	
AMPLIFY shared technical code	10_116_1_1	D	That- that's completely wrong.	
ADHERENCE : report adherence	10_117_1_1	P	Any- I- I mean	P
	10_117_1_2	P	um so um I've been taking Zantac.	
	10_118_1_1	D	Okay.	
AMPLIFY shared technical code	10_118_2_1	D	What size Zantac, Zantac?	not P
	10_119_1_1	P	[Oh, right.	
	10_120_1_1	D	One hundred and fifty] or three hundred?	
	10_121_1_1	P	Oh, I'm sorry, I don't know.	
	10_122_1_1	D	That's all right.	
	10_122_2_1	D	The box is either pale blue or dark blue.	
	10_123_1_1	P	Oh, ah .. ah I know the foil's brown.	
	10_123_2_1	P	I don't know whether it's different colour foils.	

GSP Phase	Clause ID	Spkr	Text	Semiotic agent
	10_124_1_1	D	Is it that blue?	
	10_124_2_1	D	Or, is it [more	
	10_125_1_1	P	( ) It's that] it's that long box.	
	10_126_1_1	D	It's that [( ) box?	
	20 turns omitted			
	10_156_2_1	D	So, if you're on the Zantac, ah, yes,	D' P
	10_156_2_2	D	if you want to have the grapefruit juice	
	10_156_2_3	D	that'd be fine, but not so essential.	
	10_157_1_1	P	Yeah, yeah, yeah, yes.	
	10_158_1_1	D	And, there's something else?	D
	10_158_2_1	D	.... Yeah, this having the grapefruit juice an hour afterwards makes absolutlely no sense ..	
	10_158_2_2	D	and don't worry about it.	
	10_159_1_1	P	Okay	
	10_160_1_1	D	I don't know where your friend got that from.	not D' friend
	10_161_1_1	P	Um yeah.	
	10_161_2_1	P	I can't remember either,	not P' friend
	10_161_2_2	P	but it was in A .. PUBLICATION. Yeah yeah yeah	publication
	10_162_1_1	D	Mm. Okay.	

The patient reports that he has abandoned the treatment recommendation to take grapefruit juice (which increases the bioavailability of the antiviral saquinavir), and has substituted a pharmaceutical item which has the same effect. This episode illustrates the fact that patients' views on medicines cannot be treated merely as simple preferences, but are often products of complex negotiation between individual actors and between discourse communities – as illustrated here by recursive influence between the PLWHA community and the professional discourse communities that form part of the patient's social network. In reporting this change of treatment, the patient is reporting and validating his own agency with respect to deciding and reviewing treatment. However, he uses complex representational practices to position himself and other players in the events that have happened, and the events unfolding in the doctor's surgery, including a number of de-agentialising practices. The patient:

- *passivates* his role in the process of querying the doctor's recommendations by *activating* the semiotic objects "questions" (turn 87);

- *passivates* his role in discussing the matter with other PLWHA by using *directional transactive* semiotic processes, in which his friend is the activated party;
- represents himself in a number of ways as the *beneficialised* party, both verbal ("rang up", "was told") and mental ("reassure") in turns 87 and 91;
- represents his querying as contingent on others' actions, and on happenstance.

By contrast, the doctor *activates* himself through *possessivisation*, by representing the grapefruit option as his own philosophy (turn 100). He represents the use of Zantac as something that he might give permission for only after other options have been tried (104). This is achieved through representing himself as the *activated imperating* semiotic agent, in a construction where the patient is *backgrounded* as an individual but belongs to the indeterminate category 'people' who are told what to do by the doctor. These people are not represented as having an active semiotic role in the choice; they are involved only as *material agents*, or as belonging to *categories* of patients who have different *passive* responses to the recommended treatment ("can't cope", "don't like it" in turn 104) or who are subjected by the treatment itself ("gives them diarrhoea" in turn 104).

What is the relation of such representational practices and the patient's construal of himself at turn 85 as a "naughty boy"? Arguably turn 85 serves as a kind of macro theme (Martin 1992) or as a kind of perspective display series (e.g., Maynard 1992) for the dispreferred report of adherence that follows, but neither of these analyses explains the choice of confessional motif. Using van Leeuwen's (1996) framework, we can characterise the representation of the patient in this turn as *passivated, circumstantialised* and *categorised: appraised.* In addition, this as an instance of *overdetermination*, and more particularly of *distillation*, although there are aspects of *anachronism*, *deviation* and *connotation* involved. Through overdetermination, the features of one field or one category of social actors are brought in to intrude on another field or social category. In our HIV example, the patient Stephen represents himself, anachronistically, as [-adult], and [- moral rectitude/responsibility], while at the same time participating in an adult context and displaying moral autonomy with respect to treatment choices. This contrast has the

effect of *connecting* the social role of patient to the social role of pupil and/or son and their associated institutions of education and family, since these are the systems within which the category of 'naughty boy' gets its value. By association, this connects the social role of doctor with the social roles of teacher and parent, or perhaps more properly with the abstract function of disciplinarian common to all these social roles. There is also a connection to the disciplinarian function of the priest/confessor and the institution of the church (cf. Foucault 1977).

Van Leeuwen (1996) presents distillation as a category of representational practice which is often used to de-legitimise a field of discourse, but this instance of overdetermination in Stephen's consultation with his GP appears to have both a delegitimising and a legitimising function to a discourse of compliance, partly because it also involves the strategy of deviation, which tends to legitimate (van Leeuwen 1996: 65). This suggests that deviation from the doctor's recommendation cannot be discussed straightforwardly. It suggests that the rules of the game, by which patients are to carry out the treatment recommendation made by their doctors, may be broken in any particular instance, but must not be dismantled or treated as no longer in force. I am not suggesting that there are not good reasons for patients to stick to a treatment regimen or to take the advice of their doctor, merely that the semantics of obligation and rule apply in their breach at least as much as in their keeping. In this way, such usage works to reinforce the legitimation of paternalistic discourse of medicine. On the other hand, such tropes of paternalism can be used as a foil for increased patient agency. Elsewhere my co-authors and I have argued that such discourse practices indicate an incomplete and unequivocal change away from a compliance model to a concordance/adherence model of managing treatment (Candlin et al. 1998).

If we think of the above factors as aspects of the institutional order of medicine, it is interesting to consider whether there are any logogenetic factors pertaining to the interaction order which lead to the "naughty boy" construal in this particular instance. To do this we can compare the preceding question from the doctor with the construction in turn 84: "How are you going with the saquinavir, with taking it with the grapefruit juice...?"

Table 6.16 Comparison of questions in Consultation 10: Martin and Stephen

Clause ID	Spkr	Text	Main participant	Evaluation
10_10_1_1	D	Yeah.		
10_10_2_1	D	Well, how did it go on the medication?	it/ experience	how going?
10_11_1_1	P	Oh right.		
10_11_2_1	P	Um, ye, it seems to be going okay.	it/ experience	okay
10_84_3_1	D	And, and how are you going with the saquinavir, with [[taking it with the grapefruit juice or the food or whatever?]]	P	how going?
10_85_1_1	P	Well this is [[where I've been a naughty boy]].	P	naughty boy

Arguably, in both cases the patient takes his cue from, among other things, the representation practices used by the doctor. In turn 10, the patient as a social actor is *excluded* from the representation. Grammatically, the Medium of the action is "it", and there is an abstract circumstance of location ("on the medication"). The patient is however contextually inferable as the entity that is "located" on the medication, and therefore he is also inferable as the experiencer and judge of how "it" went. The semiotic strategy of excluding the patient from the representation of the social action has the effect of conveying him as the observer of the performance of the medication, and it is in these terms that he replies. The patient presents the treatment as successful in terms of side effects.

By contrast, in turn 84, "And how are you going with the saquinavir, with taking it with the grapefruit juice or the food or whatever?", the patient is represented as the observed and evaluated phenomenon rather than the observer, through a number of semantic and discoursal factors. These factors include the fact that they are further into the consultation and have already covered the issue of side effects; and also the fact that grapefruit juice is referred to, thus explicitly invoking the practices involved in dosing. A particularly important feature is the grammatical representation of the patient as the Medium, Subject and Theme in the second version: "How are *you* going", rather than "How did *it* go". This has the semantic effect of *personalising* and *activating* the patient as a material Actor. Additionally, in the second version the

Circumstance incorporates an embedded clause (taking it with the grapefruit juice), where the patient is again the implied Actor. The patient takes his cue from this representation and responds by evaluating himself and his own behaviour.

There are three questions to be considered here that pertain to the issue of loose structuring between social practice and discourse practice. The first question is a question about the strength of the connection between context and semantics: is it possible to conduct the contextual move of evaluating adherence without invoking the semantics of compliance and patient blame when things have not gone well? I would argue that it is theoretically possible, but that the meaning potential of the genre of medical consultations – in terms of contextual configurations and in terms of phasing – has been so tightly structured and tightly linked with particular configuration of meaning potential at the semantic level that it is very difficult to change. At the moment it seems to be possible for patients to *invert* (in van Leeuwen's sense) the representational semantics of compliance as a way of 'getting away with' acts of non-compliance, but this may serve to reinforce the role expectations associated with compliance models, when it might be better, instead, to develop new models based on strategy and capacity building rather than willpower (cf. Race et al. 2001; Jones et al. 2000). It may be possible for doctors to take the lead in breaking the hold of the representational practices that invoke paternalistic relations around adherence, much in the same way that geriatricians have been shown sometimes to resist their patients' use of ageist discourse (Coupland and Coupland 1998, 2000).

The second question is what happens to the ongoing relationship between the doctor and the patient when the patient is forthcoming about aspects of treatment that they have queried or that they have not carried out according to the treatment plan. In this consultation, the patient's querying of grapefruit juice, which has occasioned both paternalistic and agentive representations, is followed by another episode (turns 163 to 198) in which the patient brings to the doctor's attention a possible drug interaction, as displayed below.

Table 6.17 Extract 2 from Consultation 10: Martin and Stephen

GSP phase	Clause ID	Spkr	Text	Semiotic agent
PROPOSE: describe treatments: Rx interactions	10_163_1_1	P	Yes, um, the other thing I found Martin is [[um one of the things, that um i- apparently um doesn't interact with or can interfere with is- is the Adalat that I take]].	P
	10_163_2_1	P	Was you aware of- of that?	D?
	10_164_1_1	D	Oh, no::. ..... RIGHT. ((INTONATION))	
	10_165_1_1	P	So, I mean	P
	10_166_1_1	D	I (would)	
	10_167_1_1	P	it just s::ays int- may interfere, so	leaflet
	10_168_1_1	D	Yes .... I was given a booklet about that the other day.	(background ed)
	10_168_2_1	D	I must have remembered some pieces	D
	10_169_1_1	P	Was the ah festival in the um ah festival centre, ah?	
	10_170_1_1	D	No, it was actually in the Barossa Valley.	
	10_171_1_1	P	Oh, in the Barossa [Valley itself.	
	10_171_2_1	P	Oh right.	
[Parallel context, subtext]	10_172_1_1	D	In all the various vineyards and things.]	
	10_173_1_1	P	Oh right.	
	10_174_1_1	D	I was given these information sheets yesterday.	(background ed)
[Facilitating context/ subtext]	10_174_2_1	D	.... Look, I'm not going to find it.	
	10_175_1_1	P	Yeah, yeah, um	
	10_176_1_1	D	I'll phone up the people and find out.	D
	10_176_2_1	D	..... ((discussion on phone: Good afternoon, could I speak to someone I your medical department please.	
	10_176_2_2	D	Yeah. Yeah g'day, hi, it's Dr Fisher here.	
	10_176_2_3	D	I'm just checking up on saquinavir and its interaction with Adalat. Yeah.	
	10_176_2_4	D	Well, yes there is.	
	10_176_2_5	D	It's in the patient information sheet.	
	10_176_2_6	D	Right. Yes. Yeah, any further information	?Drug company people
	10_176_2_7	D	Yeah. ((v. long pause)) Yep. (( )) I've got it, yeah. Great. Right. Any reports of anything?	
	10_176_2_8	D	Great.	
	10_176_2_9	D	Yes, I do, inadvertantly.	
	10_176_2_10	D	So:: .. No they haven't.	
	10_176_2_11	D	So, I'll just watch his blood pressure and go from there.	
	10_176_2_12	D	OK. Thanks a lot. OK. Bye.))	
PROPOSE: describe treatments	10_177_1_1		Great.	
	10_177_2_1		Yeah no, it's only a potential side effect.	
	10_177_3_1		Because this is such a- a new drug [[ah .... there are lots of things they don't know about it]],	

GSP phase	Clause ID	Spkr	Text	Semiotic agent
	10_178_1_1	P	Yeah sure.	
	10_179_1_1	D	like interactions with other drugs.	
	10_180_1_1	P	Yes.	
AMPLIFY shared technical code	10_181_1_1	D	But the saquinavir and the Adalat are both CLEARED by the same pathway in your liver.	
	10_182_1_1	P	Right	
	10_183_1_1	D	And, so it could be that there's a basically a traffic jam, effect,	
	10_183_1_2	D	where only a little bit of the saquinavir is metabolised	
	10_183_1_3	D	and a little bit of the Adalat's metabolised,	
	10_183_1_4	D	and so you build up and have extra .. levels of drug in your blood.	
	10_183_2_1	D	With the saquinavir, that actually doesn't matter	
	10_184_1_1	P	Right.	
	10_185_1_1	D	and .. that's the same thing that we try to do with the Zantac, get your blood levels up a little bit higher.	D+ /instituition
	10_186_1_1	P	Yeah, [yeah.	
	10_187_1_1	D	So that's] fine.	
	10_188_1_1	P	Right.	
	10_189_1_1	D	If you have too much Adalat in your system,	
	10_189_1_2	D	it could be that we're dropping your blood pressure down TOO MUCH,	
	10_189_1_3	D	and, you're going to get dizzy spells, feel tired, .. and things like that.	
	10_190_1_1	P	Right.	
ENUNCIATE: enunciate decision	10_191_1_1	D	So [[all I'm going to need to do]]is [[just watch your blood pressure a little bit closer than [[I have been up till now]]]].	Drug Co" D
	10_192_1_1	P	Fine.	
	10_193_1_1	D	And] just see what it does to you.	
AMPLIFY	10_194_1_1	P	So the Adalat's not going to destroy the effectiveness of the saquinavir?	P
	10_194_2_1	P	That- that was my concern.	
	10_195_1_1	D	No.	
	10_195_2_1	D	If anything,	
	10_195_2_2	D	make it more effective.	

In the discussion about Adalat, the patient initially represents himself as *activated* in the process of "finding", whereas the doctor represents himself as *passivated* and *beneficialised* in the process of "being given" a booklet/some information. He then activates himself in the process of phoning and checking, but *differentiates* himself

from the primary knowers who are left *genericised* as "the people", "someone in your medical department" (turn 176) and indeterminate as "they" (turn 177).

One of the effects of these representational practices is to construe the doctor's action as mediated by a social and informational network in which the doctor's responsibility for expert advice is dependent on institutionalised rather than personalised sources of information and advice. The patient is not directly connected to such sources, but is directly connected into the process. Thus there is no need for the doctor to construe his checking as "backstage" in Goffman's sense (Goffman 1969/ 1959). The patient's grapefruit/Zantac initiative seems to have been received by the doctor as unnecessary interference with his recommendations, which we can infer from the deep sighing at turn 92 among other cues[1]. By contrast, the Adalat query appears to have been received by the doctor as a valuable contribution to joint treatment management, and by this point he has accepted the substitution of Zantac for grapefruit juice and has claimed ownership of Zantac as a treatment strategy (turn 185). In order to achieve the kinds of therapeutic relationships which facilitate shared decision-making, it is important that a patient can bring each successive issue of concern to the table in this way, whether previous independent initiatives were ratified by joint discussion or not.

6.5.3 Shared decision-making, but still unequivocal roles

This data extract revisits the consultation between Trevor and Michael analysed in Chapter 4. In order to emphasise how the current approach positions the sociosemantic description of agency as a mediating layer between grammatical description and contextual description, the main grammatical participant roles are shown, along with the semantic category of Semiotic Agent discussed throughout this chapter.

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[1] This incorporation by the doctor of the patient's policy about Zantac can be seen as the reciprocal of the way that the patient incorporated reference to the doctor's policy about Bactrim in Consultation 10 above. Note that this is not the same patient.

Table 6.18 Deferral of treatment change in Consultation 37: Trevor and Brian

Consult& clause ID	Spk	Text	grammatical agency			
			Semiotic Agent	Agent	Medium	Range
37_187_1_1	D	Now, so (what I've got here is) -	D		D	semiotic matter
37_187_1_2	D	this is on the thirteenth of March obviously- and			record	time
37_188_1_1	P	Yeah, we'll go-			P+	semiotic matter
37_189_1_1	D	(reads aloud as he writes)) Plan after discussion. Number one=			semiotic object	
37_190_1_1	P	=(We were fixing up) [[what drugs to drop]].	P+	P+	treatment	
37_191_1_1	D	That's right.	D+		semiotic matter	quality
37_191_2_1	D	Step one is discontinuation of drugs, first vincristine then ddI if necessary,	D		semiotic object	treatment change
37_191_2_2	D	in brackets I've written			D	
37_191_2_3	D	leaving him on D4t and nevirapine.	step/ plan	plan	P	treatment
37_191_3_1	D	And then number two I've written,			D	
37_191_3_2	D	checked CD4-stroke-viral load AGAIN today plus liver function tests, amylase and haemoglobin for blood count.		D	HIV virus/ T cells	
37_191_3_3	D	Send off to Prosser."		D	tests	
37_191_4_1	D	So now we've got-	D+		D+	semiotic matter
37_191_4_2	D	we know			D+	
37_191_4_3	D	you've changed one set of drugs;		P	treatment	
37_191_5_1	D	we know [[what the viral load is]].			D+	HIV virus
37_191_6_1	D	The viral load shows without question	D+ ' VL		test results	
37_191_6_2	D	that .. the antivirals .. aren't working.			treatment	
37_191_7_1	D	Yeah.			-	
37_192_1_1	P	Well maybe because at that stage	P		-	
37_192_1_2	P	<< (like) that was a week before,>>			event	time
37_192_1_3	P	would it- would it show in that week?	->D' VL		non-adherence	
37_193_1_1	D	Yeah.			non-adherence	
37_194_1_1	P	When			-	
37_195_1_1	D	Yeah.			-	
37_195_2_1	D	If had- if you'd STOPPED, for example,			P	
37_196_1_1	D	Yeah.			-	

Consult& clause ID	Spk	Text		grammatical agency		
			Semiotic Agent	Agent	Medium	Range
37_196_2_1	P	It probably would have shown in that?			non-adherence	
37_197_1_1	**P**	**Okay well, we'll leave it for another- nother two weeks**	P+	P+	change/ decision	
37_198_1_1	D	Okay.			-	
37_199_1_1	P	Cos I get the dd- D4t today		P	treatment	
37_200_1_1	D	Yeah.			-	
37_200_2_1		Yeah.			-	
37_203_1_1	P	Give it another bash solid, [( ).		P	a bash	
37_204_1_1	D	Okay.			-	
37_204_2_1	D	All right.			-	
37_204_3_1	D	I think that's reasonable,	D		decision	quality
37_205_1_1	P	which I can do.			P	
37_205_2_1	P	Then we can go .. do another test and just in case it was JUST THAT.	P		P+	test
37_206_1_1	D	Yeah, okay.			-	
37_207_1_1	P	Um.			-	
37_208_1_1	D	((laughs)) That's reasonable.	D		decision	quality
37_208_2_1	D	Is there anything [[to see or feel]]?	D+		symptom/ sign	
37_209_1_1	P	Um, slight .. colour change, <<that's about it>>, in the lesions.	P		change	
37_210_1_1	D	In the ones in the groin?			-	
37_211_1_1	P	In the groin, yeah.			-	
37_211_2_1	P	They've become oh- I- I- I- I THINK they've become lighter.			symptom/ sign	quality
37_211_3_1	P	They're not as dark as they used to be.			symptom	quality
37_212_1_1	D	Oh, show me quickly then.	D"! P		P	symptom
37_213_1_1	P	You just want			D	
37_213_1_2	P	me to get my pants off, don't you? ((laughs))		P	clothes	
37_214_1_1	D	Very funny.			-	
37_214_2_1	D	Ah, actually ah, well this lot DO.			symptoms	quality
37_215_1_1	P	Yeah, they seem to be a lot lighter.	P		symptom	quality
37_215_2_1	P	One of them's - Oh that one's- that seems to be .. getting smaller.			symptom	quality
37_216_1_1	D	Oh, you're right.	D		P	quality
37_216_2_1	D	There's two actually.	D		symptom	
37_216_3_1	D	Did you point that out to Prosser?	P		P	semiotic matter
37_217_1_1	P	Eh?			-	
37_218_1_1	D	([ )			-	
37_219_1_1	P	I did].			P	semiotic matter
10 turns omitted						
37_230_2_1	D	((writing down)) "Reports lighter-	P		P	symptom

Consult& clause ID	Spk	Text		grammatical agency		
			Semiotic Agent	Agent	Medium	Range
		lighter colour to KS lesions in groin.				
37_230_3_1	D	On examination I agree".	D		D	
37_231_1_1	P	Um, I don't think my nodes are up as .. much either.	P		symptom	quality
37_232_1_1	D	Oh yeah.				
37_232_2_1	D	Number three, u::m	D			
37_233_1_1	P	At this point in time.				
37_234_2_1	D	CD4 count, thirteenth of the three, two hundred and. What was it?			Tcells	quality
37_234_3_1	D	Two hundred and [two	P		Tcells	quality
37_235_1_1	P	Two] forty three I think it was.			Tcells	quality
37_236_1_1	D	Two forty.	D-> P		Tcells	quality
37_236_2_1	D	Good.				
37_236_3_1	D	Up.			Tcells	quality
37_236_4_1	D	(But, viral load was" three hundred and eighteen thousand, wasn't it?			VL	quality
37_237_1_1	P	Yeah.	P			
37_238_1_1	D	((still writing)) Ah. And there=.				
37_239_1_1	P	( )				
37_240_1_1	D	Four.				
37_241_1_1	P	( )				
37_242_1_1	**D**	**Um, I'll put**	D"		D	
37_242_1_2	**D**	**he'll probably need a change of antivirals,**	D"D			
37_242_1_3	**D**	**but Michael has asked**	D"D"P		P	
37_242_1_4	**D**	**to postpone this for a two week period"**			change	
37_242_1_5	**D**	**<< ah, what'll I write? ((coughs))>>**	D" D		D	semiotic matter
37_242_1_6	**D**	**while he improves his compliance.**[1]		P	treatment	
37_243_1_1	**P**	**( )**			-	
37_244_2_1	**D**	**No-one else is going to read it.**	other clinicia n		other clinician	
37_244_3_1	**D**	**Okay.**				
37_244_4_1	**D**	**Um, that sums it up though.**	written record	written record	semiotic matter	
37_245_1_1	P	Yeah.				
37_246_1_1	D	All right.				
37_246_2_1		And what about domestic			situation	quality

[1] From a grammatical point of view the clause numbering in Complex 242 should indicate that the doctors' clause "ah what'll I write?" is inserted into the surrounding clause complex, and does not have a paratactic or hypotactic relation to the clause as a whole. However, it can be viewed as forming a grammatical relation of Token: Value and more semantic relation of Projection: Projected, with the clause that directly follows it "while he improves his compliance"; thus, it has been included in the clause complex in sequence.

Consult& clause ID	Spk	Text		grammatical agency		
			Semiotic Agent	Agent	Medium	Range
		arrangement?				
37_247_1_1	P	I've moved.			P	
37_247_2_1	P	He's moved.			P's lover	

Loose structuring in language and in the institution of medicine

In this extract, the doctor and patient are deciding what to do about treatment in the face of mixed test results. The doctor and patient have discussed the results earlier in the consultation, then moved on to discussing another issue, and are returning to the issue of treatment. The doctor is writing in the patient's record as they talk through the issues.

In turn 187, the doctor is referring to what he's already written. As *Speak*er, the doctor is clearly the Animator of the written record, in Goffman's (1981) sense. As the writer of the record he has control of the authorship of the written record as well, but since he is writing and speaking aloud he is providing opportunity for the patient to hear and, potentially, to comment. This action implies a construal of the context of decision-making as one in which it is appropriate that the patient share the articulation of the plan, so in a sense the doctor and patient can be considered as joint Principal (in Goffman's sense), and as sharing the semiotic agency in the sense I have outlined above, of making an impact on states of affairs through semiotic means. The doctor's reference to the first person singular in turn 187 suggests that he *differentiates* himself from the patient in taking a role of primary semiotic agent for the written record, and as the doctor continues to read and write the record this role of primary semiotic agent extends over the unfolding text, until it is interrupted or challenge. This effect is shown by the arrows running down the column marked "semiotic agent" in the transcript table above. As we shall see below, the responsibility of foregrounding semiotic agency, including the agency of the patient, is something that the doctor attends to but which is not unproblematic for him.

At turn 190, the patient interrupts but elaborates the doctor's prior move ("*we were fixing up what drugs to drop*"), attempting to position himself as a joint semiotic agent. He does this by mapping himself and the doctor, through the first

person plural, into the role of Agent in a material process, used to construe a semiotic action. This is a case of the strategy I have identified above of interactants (and registers) exploiting the facility of material transitivity to convey semiotic agency through process metaphor. What might be the point of the patient's attempt to foreground his own agency at this point? It could be interpreted as a challenge to the status of the decision (in the sense of *we hadn't finished* fixing up what to drop), or as a confirmation of an agreement about its status. So it is either a claim for more semiotic agency or, at least, a claim for an acknowledgment or acceptance of the patient's active involvement in deciding about treatments.

The doctor continues to represent the written record as his own *differentiated* account, but at turn 191 switches to rehearsing the knowledge being brought to bear on *"fixing up what drugs to drop"*, and presents this as shared by no longer differentiating himself from the patient. Here the doctor represents himself and the patient jointly as *activated, participants* in *possessing* knowledge, and as *beneficialised* joint receiver of messages from the viral load, which is *activated* as *Sayer,* as seen in clauses 4_1 to 7_1 below.

37_191_4_1 D So now we've got-
37_191_4_2 D we know
37_191_4_3 D you've changed one set of drugs;
37_191_5_1 D we know [[what the viral load is]].
37_191_6_1 D The viral load shows without question
37_191_6_2 D that .. the antivirals .. aren't working.
37_191_7_1 D Yeah.

As pointed out in earlier discussions of this text, turn 191 is a crucial turning-point in this decision episode. It is at this point, immediately after the doctor has announced what the viral load unequivocally shows, that the patient is successful in his third attempt at having some influence on the doctor's reasoning. It often seems to be the case in the present corpus that such moves occur where there is a certain amount of grammatical indeterminacy. It also seems that this indeterminacy has a semantically and pragmatically productive function, and is not merely a matter of untidiness or grammatical error, which is how such phenomena are often construed in contrast with written language (cf. Schegloff 1996); rather, it is a way of playing off

lexicogrammatical structures against semantic structures which can be understood as modes of natural reasoning (Butt in press, cf. Toulmin 1958).

In this example, the main tensions are between the lexicogrammatical structure of embedding, in which elements of reasoning about treatment review are insulated from negotiability and perspective, and on the other hand projection, in which elements of reasoning are represented as attributable to some conscious agent or unconscious symbol source. The net effect here is an instance of reasoning that is difficult, but not impossible for the addressee to unpick, and this depends on the alignment between the following structural patterns and their inherent indeterminacy. I will briefly review the alternative "readings" of this pivotal section of the decision.

Grammatical structure – reading 1

The doctor's turn is heard as three clause complexes and an incomplete fragment. Under this reading clause "So now we've got..." trails off, incomplete, and the speaker "repairs" or starts again, with "We know you've changed one set of drugs". The rest of the utterance is parsed as three clauses, related in a clause complex by paratactic extension and elaboration respectively: "We know A and we know B; i.e. C".

(?)			So now we've got ...
	1	α	We know || 'β you've changed one set of drugs
+	2		We know [[what the VL is]]
=	3	α	The viral load shows || 'β the antivirals aren't working

Grammatical structure – reading 2

Alternatively, the utterance can be heard as one very complex clause with major embedding framed within a possessive relational clause, "We've got: A, B, i.e. C". The problem with this is that the structure seems to begin life as a Relational attributive and possessive structure, which represents knowledge as something possessed by the doctor and patient, jointly. The doctor and patient are *assimilated,* and *activated,* through *possessivation,* as shown in the following:

	now	*we*	*'ve*	*got*	*[[we know || x...]]*
THEME	Theme	Rheme			
MOOD	Adjunct	Subject	Finite	Predicator	Complement
	Residue	Mood		Residue	
TRANSITIVITY		*Possessor*	*Proc Rel:attrib&poss*		*Possessed*

But by the end of the doctor's turn his utterance has shifted into the shape of a Relational identifying & possessive structure, in which the doctor and patients are no longer grammatical participants. The transitive relation is between "what we've got" as Value and a string of knowledge items which are taken together to constitute Token.

what we've got	=	*[[we know || x]]* +*[[we know [[y]]* =the VL shows *|| z]]*
Value		Token

Grammatical structure – reading 3

A third reading is that this construction can be seen a recursive series of projections[1] of knowledge shared by the doctor and patient as semiotic agents, and mediated by

[1] Strictly speaking the first relation is a quasi-projection only. The whole of the clause complex from got onward is ambiguous between functioning as the Range in a Possessive Relational clause, functioning as an Identified in a Relational Identifying clause, and functioning as the projected element or elements in a Mental or Verbal clause complex. I have preferred to analyse it as a complex projection, since this best captures the logico-semantic relations that make these clauses function as one unit.

the semiotic agency of the inanimate clinical tool, viral load. Schematically, the chain of projection between these semiotic agents can be presented as in Figure 6.22 below. The patient is presented as having access to the knowledge that the drugs aren't working, via the semiotic agency of the viral load results, which are in turn accessed via what the doctor knows and has collated as evidence.

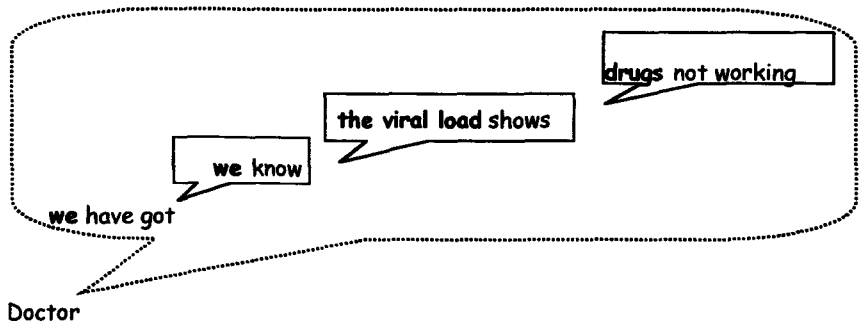

Figure 6.22 Nested projection and semiotic agency, Consultation 37, turn 191

In conjunction with the grammatical and semantic indeterminacy, there are indeterminacies of context at this juncture, and at many other crucial junctions throughout the corpus. The doctor seems to construe his move as summing their joint interpretation of the markers (BEARINGS phase) and moving on to proposing change of treatment (PATHWAYS phase). For the patient, the BEARINGS phase is not complete: there is still the question of evaluating/interpreting his treatment adherence, which may mean the viral load does not show what the doctor has taken it to show. There is a need for the patient to find an acceptable way of intervening in the interpretation, and there are a number of messages that need to be got across. The first is that there is a missing 'symbol source' in the doctor's nested series of projections, namely the patient's own voice, reporting his adherence. This symbol source must be taken into account with the viral load, and taken together they indicate that the drugs have not been given a proper chance to work. This instance of negotiation of space for the patient's view to be incorporated as a legitimate

component of the clinical reasoning that determines whether treatment is changed may provide some window on what Ahearn (2001) referred to as a kind of parallel loose structuring in language and social agency, and what Erickson (2001) referred to as wiggle room providing space for social transformation. In this instance, the patient is structured into a role of deferring to the doctor's expertise with regard to diagnosis and the interpretation of technical symbolic tools, such as viral load test results. It is still possible for him to find a way to influence and re-route the interpretation. But it is only possible for the patient's action to be accomplished (i.e., moving from capacity to praxis) when there is a suitable point in the talk at which the alignment of context, semantics and grammar can be reconfigured.

It is not entirely clear what all the contingencies are – what might happen if the patient directly contradicted the doctor – but we do know from this instance that one of the consequences of not getting the alignment right is that the patient's contribution about adherence will be heard by the doctor as an issue which is not relevant to the current phase of the context, and which is therefore to be postponed until interpreting the viral load is complete. Numerous such instances of capturing the right moment to temporarily realign the context-discourse hook-up *may* have the effect, in some discourse communities, of reconfiguring practices on a more permanent basis, such that patients are seen to have a role in marshalling and interpreting clinical evidence for decision-making.

The patient's move at turn 197 functions to *differentiate* him as a semiotic agent from the shared *principalship* of the above message. There follows a period of re-examination of what the viral load test might in fact have shown, with the result that the change of treatment proposed earlier is postponed, and that the assertion that "without question the antivirals aren't working" is replaced with something less certain. Thus, throughout this phase the patient is enacting the role of semiotic agent, although his choice of speech function allows him to share this role with the doctor rather than usurp it. By presenting his contributions as "checking" questions, the patient keeps the doctor positioned as the primary knower, or as the semiotic agent capable of confirming or denying the patient's hypothesis (cf. Labov and Fanshel 1977).

Having completed this move to re-project what the viral load shows, the patient enunciates a joint decision to postpone the treatment change:

37_196_2_1 P It probably would have shown in that?
37_197_1_1 P Okay well, we'll leave it for another- nother two weeks

In the terms outlined above, the patient is the Animator, Author and Principal of this message, and shared material agent of the projected action, with the doctor. Yet when the doctor incorporates this into the record, his attribution of semiotic agency suggests a different view of the patient's role:

37_242_1_1 D Um, I'll put
37_242_1_2 D he'll probably need a change of antivirals,
37_242_1_3 D but Michael has asked
37_242_1_6 D to postpone this for a two week period"
37_242_1_4 D << ah, what'll I write? ((coughs))>>
37_242_1_5 D while he improves his compliance.

Writing and speaking aloud again here, and using projection among other semantic strategies, the doctor constructs a record of the decision, if not the decision itself. In clause 242_1_2 the doctor represents the new decision more as a postponement of an inevitable decision. The patient is then represented in clauses 242_1_3 as *asking* for this postponement. As Baynham and Slembrouck point out (1999), the key function of reported speech is to invoke and represent social networks. They argue that not only does the use of reported speech deflect responsibility for the speaker's claims or values to some other source, but that it also attributes credibility to the party whose speech is reported. In the case of Trevor and Michael, there appear to be a number of potentially conflicting interpretations available as to what the doctor's projection is doing.

Whenever one uses the semantic strategy of reported speech – or more strictly, projection of meaning rather than wording – one is forced pass some judgement on the interpersonal aspects of the speaker's action, and the doctor's choice here arguably modifies the legitimate participation established by attributing the decision to the patient, as suggested above. The doctor chooses to represent Michael's verbal action as *asking*, rather than *suggesting* , or as *saying* what he

wants, or as *telling* the doctor what to do, to name a few alternative options. Instead of projecting Michael's utterance as verbal action (reported speech or direct speech), he might also have projected it as mental action or semiotic action more generally – Michael *prefers* to do x, Michael has *decided* to do x. Each of these choices has its own semantic implications with regard to the overall portrayal of agency, largely through what Whorf called "configurative rapport" between different structures and functions within the grammar of a language (Whorf 1956). The doctor's choice of *to ask* – itself a choice within the Experiential grammar of English – has a particular rapport with the Interpersonal grammar of speech function. Representing Michael's speech as *asking to do something* construes his verbal act as a demand, which is arguably a reclassification of the speech function in Michael's own utterance. Additionally, the process *to ask* has a rapport with the semantics of modulation, in particular with permission. Permission (*you may come in, you are allowed to leave early*) and necessity (*you must come in, you are required to leave early, you have been asked to leave*) are characterised as "passive modulation" and tend to construe extrinsic agency (Halliday 1976, cited in Thibault 1993).

This external moral agency is echoed in the choice of the modal "need" in clause 242_1_2 (*he'll probably need a change of antivirals)*, and again in the enhancing hypotactic clause at 242_1_5 (*while he improves his compliance*). In the latter, the complex semantics of the construct "compliance" suggests a division of labour between semiotic agency (doctors make treatment plans and instructions) and material agency (patients carry out the material action of complying with another's instructions), since one cannot "comply" with oneself.

The explication throughout this chapter of the grammatical basis for the depiction of agency does not mean that the grammar is the final arbiter of agency, or even of the way in which a configurative rapport operates. It is only with sense of the typical agentive roles of doctors vis-à-vis patients that we can appreciate that even representing a patient as asking a doctor to enact a certain treatment plan counts as an upgrade from the more typical portrayal of patients as either passive recipients of information or as involved in decision-making but not in a position to declare a non-consensual recommendation or enunciate a non-consensual decision. That is the

value of such an instance from a paradigmatic point of view, in terms of marked and unmarked choices with the context or register.

Alignment as inherently partial and ongoing

As we have seen above, Trevor and Michael are not entirely aligned in their view of the agentive roles of patients and doctors, nor are they entirely aligned in their views about what will need to be done about the antiviral drugs. Trevor is not convinced that leaving the change of drugs until Michael has had a chance to "*improve his compliance*" will be effective, and yet Michael's plan prevails, at least for the time being. In fact, from subsequent consultations it appears that the postponement was not successful. By contrast, in a similar scenario in Consultation 29, which we saw in Chapter 5, where Trevor and another of his patients, Neil, have to decide whose views to prefer, the decision falls the other way. Trevor convinces Neil not to change from AZT at that time, but subsequent consultations reveal that AZT appears to have been the problematic agent, the drug to which Neil had become acclimatised, and so they change it two consultations later (Consultation 31).

I have argued that Consultation 37, like Consultation 29, is an instance of collaborative decision-making, in which the doctor and patient share responsibility for interpreting results and for articulating treatment plans, despite the fact that there is not complete agreement about the most likely outcome. Through this interaction there runs a strong sense of joint responsibility for the planning, reviewing and carrying out of treatment procedures, although their representation does suggest that, not surprisingly, agency passes from both the patient and the doctor jointly to the patient univocally, as deliberation melds into the enunciation of plans, and then again into the material acts that implement those plans.

At the same time, there is some level of conflict about the degree to which these roles are equally appropriate for each interactant. The doctor appears to orient to an institutional order in which treatment decisions must be ratified by clinicians, even if the processes which culminate in them and the processes of articulating them are to be shared. In a kind of coda to this episode, the doctor makes a comment that can be seen to reflect his own unsettledness about the dominance of the institutional

order, even as he is invoking it by writing down that the patient is to "*improve his compliance*" – he says, "*Nobody's going to read it, okay. That sums it up though*".

The benefit of the multidimensional approach illustrated in the analyses in this chapter and summarised in the network is that it shows how reported speech, modality/modulation and other features can be integrated into an overall picture that allows us to identify the particular patterns of speech in medical consultations through which patients and doctors are positioned as active, responsible, volitional, effectual, rational agents in the process of making decisions about treatment. These methods allow us to relate the grammatical resources used to construe agency, and track them throughout interactions, showing how patients and doctors negotiate their roles and views as these unfold.

By way of illustrating the benefits of this approach, Table 6.19 below summarises the analyses shown message by message in Table 6.18, comparing the two very different pictures of how agency is distributed in Consultation 37, one given by the multidimensional method described here, and the other by an analysis of grammatical Agent alone. Table 6.19 thus presents an indicative measure of the extent to which relevant actors can be identified as agentive in the process of deciding treatment, by each method. For the multidimensional approach, this measure is given by the number of messages over which the social actor/ entity in question can be read as having some agentive scope, whether *visibly* represented in the text of that particular message, or *backgrounded* but contextually available, as described in sections 6.2 and 6.3 above. The summary analysis for grammatical Agent is given by the number of clauses in which the social actor/ entity in question appears as the Grammatical Agent. The total number of clauses/ messages in each case is 94[1].

[1] A measure of relative frequency could be derived for grammatical Agent but this would not be appropriate for Semiotic Agent.

Table 6.19 Comparison of multidimensional semantic analysis of agency with grammatical level transitivity/ergativity analysis in a section of Consultation 37: Trevor and Michael

Social actor/entity	Semantic level Representation No. messages in which social actor is Semiotic Agent	Grammatical level Representation No. clauses in which social actor is Agent
Patient	25	6
Patient+	9	2
Doctor	31	2
Doctor+	8	0
Viral Load	9	0
Treatment plan	1	1
Medical record	1	1

As Table 6.19 shows, a unidimensional grammatical analysis (right hand column) would suggest that the patient is the most agentive participant in Consultation 37, and that there is very little agentive action in the field being construed. The analysis shown in the left column much better reflects the complex negotiation of agency that takes place in this interaction.

6.6 Summary of this chapter

In this chapter, I have examined how agency is constructed in the particular context of treatment decision-making in HIV medicine. There are five preliminary but important findings about the relationship between agency and shared decision-making that can be drawn out of the discussion in this chapter:

1. Doctors and patients produce complex and shifting construals of their own and each others' agentive roles with regard to decision-making about treatment.
2. There appears to be an association between whether patients are represented as agents and whether they act as agents in treatment decision-making.

3. Where patients are represented as active agents in their own health care and in the process of making decisions about their own healthcare, they are more likely to take such an active role, but this does not necessarily lead to shared decision-making.
4. Shared decision-making seems more likely to occur where both doctors and patients are construed as agentive, each by the other, than when only the patient or the doctor is represented as agentive, or when each participant emphasises their own agency.
5. Representing another social actor as agentive may therefore count as an instance of enacting an agentive, competent self, as seen for instance in Anspach's analysis of agency in medical case presentations (Anspach 1988) and in Duranti's study of agency and Samoan public life (Duranti 1994), except that unlike these, in HIV decision-making consultations this is not usually at the expense of the other party, e.g., by attributing responsibility for unreliable information, or blame for malicious acts, to another party.

These findings about the context of HIV decision-making are related to a set of findings about descriptive method:

6. The agentivity of contextually and/or textually differentiated participants need not be modelled as a limited resource, but may be modelled in other ways (cf. Foucault 1977). Thus it need not be a question of either the patient or the doctor, or some other participant, being the dominant agentive figure, but a question of the way the agency of one participant is construed by the participants as a resource for the agency of another. This applies to animate and inanimate actors, namely patients, doctors, institutions, treatments, and abstract tools such as viral load tests. Each of these is shown above to be construed as performing some action which enhances the capacity of doctors and patients to act with a view to improving the patient's health.
7. This shift towards conceptualising agency as (potentially) reciprocal rather than competitive requires a shift in analytical focus which construes semiotic action as (potentially) effectual, such that the most dynamic participants in medical

decision-making contexts tend to be those construed as engaged in semiotic action rather than material action (cf. S.Candlin 2002, Matthiessen 1998).

8. A related finding is that the grammar of projection, verbal and mental processes, modality and mood projection, and identification are seen to be crucial realization resources for construing agency in the context of HIV treatment decision-making.
9. A simultaneous shift in analytical focus is required – from a focus on the grammar alone, to a focus on the contextually salient alignments between grammar, semantics, and context (Butt 2000a,b); and on the degree to which doctors and patients share such alignments, either from the outset of their interaction or by processes of negotiating and renegotiating perspectives (Moore et al. 2001, Adelswärd and Sachs 1998).
10. In addition, every contribution to a decision-making episode is simultaneously (cf. Linell 1990):
    i) a contribution to the ongoing portrayal and enactment of the speaker's own agentive role
    ii) a contribution to the picture of the role of the other, and
    iii) a comment on the other's construal of these phenomena.

The discussion in this chapter has shown that agency is a highly complex and sensitive area of meaning potential in the context of HIV medicine. The pathways taken by doctors and patients through this meaning potential have important practical ramifications for treatment choice, and for the extent to which decisions are made collaboratively. Since the phenomenon of agency is complex, the analytical tools used in its exploration must be able to handle such complexity. The present chapter has demonstrated one approach to this challenge, and in doing so, offers a small contribution to the program, outlined in chapter 4, of bringing social theoretical and linguistic accounts of agency to bear on each other in studies of situated practice. This approach has produced a very different picture of agency in medical discourse from the stereotypical picture of passive patients and active doctors, as portrayed for instance in fictive accounts of doctor-patient interaction (e.g., Burton 1996). It also produces a different picture from the "scenario" based accounts of decision-making

such as Charles et al. (1997), by focussing on the details of how doctors' and patients' talk constructs agency and participation, which is often left to the imagination in scholarly accounts.

A complex conceptualisation of agency is no inherent barrier to linguistic analysis, but it makes it essential to analyse agency *not* as a billiard ball to be passed back and forth between the doctor and the patient, but as a phenomenon with different modes, different timescales and different relational depths. More work is needed to see whether the approach to the representation of agency outlined here is generally valuable and feasible for researchers, policy makers or educators; and also to see whether this kind of approach can be made more rigorous and repeatable by specifying recognition or realization criteria in more detail for the categories proposed in the network. As well as the representational practices themselves, there are many questions that remain, especially in terms of i) the relation between the way doctors and patients *represent* each other as social actors and their *identification* with, and *enactment* of, certain types of roles rather than others and ii) the extent to which the negotiation of agency in this corpus is generalisable to other groups of doctors and patients in HIV medicine and beyond. In the final chapter I will briefly expand on some of these issues.