

Medical Recommendations as Joint Social Practice

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Treatment plans can be thought of as one of the products of a medical interaction. As such, treatment for illness has been investigated as an outcome measure and seems to reflect bias in some areas of the practice of medicine. Although the evidence for patterns of differential treatment is compelling, determining the source of treatment bias has been difficult. Based on detailed analysis of transcripts of actual interactions in general medicine and oncology clinics, we propose that treatment plans are negotiated through everyday language practices that work to maximize agreement. We demonstrate that, on the level of individual medical encounters, patient agency is both apparent and operative and that physician power does not unilaterally determine outcomes. Thus, this investigation goes beyond the abstract study of physician and patient preferences or prejudices, focusing closely on the consequences of actual talk in settings where medical recommendations are being made.

Treatment plans can be thought of as one of the products of a medical interaction. As such, treatment has been investigated as an outcome measure in health research and appears to reflect bias in some areas of the practice of medicine. It has been shown, for example, that older people receive less aggressive cancer treatment (Allen, Cox, & Manton, 1986; Bennett et al., 1991; Chu, Diehr, & Feigl, 1987; Greenfield, Blanco, & Elashoff, 1987; Newcomb & Carbone, 1993; Silliman, Guadagnoli, & Weitberg,

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1989; Yancik, Ries, & Yates, 1989); race and gender appear to affect the treatment of psychiatric disorders in adolescents (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995); children of low socioeconomic status are more likely to be recommended for alternative intervention strategies for remediation of language delay (Franklin & Grossman, 1990); and general practice doctors are less likely to refer elderly patients for elective surgery (Ryynanen, Myllykangas, Kinnunen, & Takala, 1997). The evidence for patterns of differential treatment is compelling, yet determining the source of treatment bias has been difficult.

Practitioners contribute to differential treatment approaches by recommendations that are based on their knowledge of standard therapies combined with their perceptions of patients (e.g., Fisher, 1983), but patient preferences also affect selection of treatment (Cuffe et al., 1995; Newcomb & Carbone, 1993). Although it is intuitively plausible that both providers and patients contribute to the final formulation of a treatment plan, research to date on treatment bias has tended to favor either retrospection methodologies, in which participants are asked to remember what went on during the medical encounter, or, more commonly, vignette approaches, in which physicians choose treatment options based on hypothetical scenarios. When patients are asked to express preferences (e.g., Yellen, Cella, & Leslie, 1994), they indicate what treatment option they might prefer given a set of options. Ultimately, the approach to the issue of bias has remained the same: tapping prescriptive beliefs of practitioners, occasionally patient preferences, but leaving the actual interaction an unstudied element.

In this article, we hope to fill in some of the details of that picture by closely examining the verbal and nonverbal interaction of doctors and patients in clinical settings. What emerges is a demonstration of how treatment plans are subtly negotiated during the medical encounter and how patients are agents shaping and choosing treatment plans. Hence, the outcome or product of the medical encounter (the treatment plan) can be associated with patient as well as physician actions. Patients both accept and resist recommendations; they do not simply fall victim to physician preferences. We are not claiming that doctors and patients are operating in a world devoid of prejudices, but we are stating that one cannot simply consider outcomes when trying to understand treatment bias, nor can one rely solely on retrospective and vignette approaches. Without a close look at actual physician-patient interaction, the details of how recommendations are structured and received, accepted or resisted, are lost.

Research on recommendations as produced through talk-in-interaction is sparse (see Roberts, 1999, for a review). However, we know from investigations into the allied concern of "advice giving" that advice that is unilaterally delivered—that is, without being made relevant at the outset or without some stepwise progression into the advisable realm—the health care worker risks meeting with resistance from the patient or client (Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Silverman, 1997; Silverman, Bor, Miller, & Goldman, 1991). These findings point to the decidedly interactive nature of giving advice.

Building on this line of research, we take a similar approach to understanding recommendations. However, in contrast to previous discourse analysis studies of treatment bias (e.g., Fisher, 1983; Todd, 1989), in which concerns about physician attitudes or aptitudes inform the analysis, we try to understand how final recommendations are arrived at by focusing on participants' actions, not their attitudes. Rather than a top-down approach to understanding medical interaction, an approach that views diagnosis and treatment decisions as influenced primarily by participants' cultural assumptions, perceived characteristics, and the aspects of the larger social setting (Kessler, House, Anspach, & Williams, 1995), we look at everyday conversational practices to see how they shape recommendations from the bottom up.

We propose that treatment plans are instances of jointly produced social action in that the negotiation of recommendations is a function of everyday language practices that work to maximize agreement. We claim that, on the level of individual medical encounters, patient agency is both apparent and operative, and that physician power does not unilaterally determine outcomes. Patients are active in negotiating treatment plans through their acceptance of or resistance to recommendations—thus embodying agency in the medical setting. Maynard (1991) has pointed out in the context of a discussion of asymmetry in clinical discourse that agency derives “partly from participants' indigenous resolution of interactive problems that transcend doctor-patient dialogue” (p. 449). We will look here at how a certain interactive problem, namely management of disagreement, is relevant for understanding how treatment plans get negotiated. It may well be that, in the face of recommendations that are only mildly agreed to, physicians revise their recommendations to maximize agreement. In this way they are not only achieving the preferred social outcome of agreement, but may also be arriving at solutions that patients are more willing to embrace as relevant and workable. To contextualize this claim, we offer the following brief overview of previous conversation analysis research on agreement.

REMARKS ON AGREEMENT AND DISAGREEMENT

The agreement or disagreement with assessments; the acceptance or rejection of invitations, offers, requests, and proposals; and the pursuit of response have all been carefully analyzed in noninstitutional settings (see Davidson, 1984; Pomerantz, 1984). These phenomena are recognizable from remarkably routine and repeated conversational patterns and sequences. Except in instances of self-deprecation, in which a disagreeing response is preferred, findings from Pomerantz on assessments and Davidson on invitations and similar phenomena demonstrate that there is a tendency to minimize stated disagreement or rejection and to maximize stated agreement or acceptance (Pomerantz, 1984). What this means is that coparticipants

avoid stated disagreements by providing instead signals of potential disagreement that may then (though not necessarily) occasion reformulation of the invitation, request, or proposal. Such signals take many shapes, including silences, "hesitations, questioning repeats, requests for clarification, weakly stated agreements, and the like" (Pomerantz, 1984, p. 77). In the institutional conversational data presented here, it is quite clear that disagreement or rejection is hedged or delayed in the same way; thus, we see the same mechanisms operating as those in everyday talk.

The essential difference between the institutional data and that of everyday conversation is that one participant in our data, the physician, is usually making the proposal, offer, or invitation (i.e., in our view, a recommendation is nothing more than a proposal for a course of action), and the patient is the one who assesses, agrees with, or refuses the proposal. In the current data, we see that, when there is hesitation or resistance on the part of the patient, physicians pursue agreement either by reformulating the recommendation (providing a subsequent version in line with Davidson, 1984) or by continuing to present evidence to justify it. In other words, the negotiation of a medical recommendation or treatment plan embodies features of everyday talk in which maximization of stated agreement is sought. This makes sense both *prima facie* and as a more profoundly sociological phenomenon. On the face of it, physicians present recommendations that they consider to be in the patient's best interest and seem to work to get patients to agree with the proposed plan. In addition, the apparent sociological tendency for participants to orient to agreement (Pomerantz, 1984; Sacks, 1987) may account for why physicians might reformulate a treatment option in the face of patient resistance, however weak or strong. Not only are they trying to arrive at a medical compromise, one that takes into account patient preferences, but they are also orienting to an everyday practice of maximizing agreement.

With these observations in mind, it can be derived logically and demonstrated empirically that patient receipt of medical recommendations affects the conversational and practical status of the recommendation. Receipt affects conversational status in that the recommendation can be agreed upon and no further conversational work is needed, that is, the topic can be closed. Likewise, the practical status of the recommendation is affected in that, if it is not accepted by the patient, then further work may be required to elicit agreement.

DATA AND ANALYTIC APPROACH

The data for this study comprise 16 videotaped consultations from an internal medicine clinic associated with a teaching hospital¹ and 21 audiotaped consultations

¹The videotape data were collected by Douglas W. Maynard at a teaching hospital associated with a large midwestern university. We gratefully acknowledge his generosity in sharing that data with us.

from a university-based oncology clinic.² Both clinics are located in a medium-sized midwestern city in the United States. The internal medicine clinic visits lasted from 3 to 40 min, and the oncology visits from 9 to 58 min. In all, 14 physicians and 37 patients were recorded.

Each clinic visit used for this analysis was transcribed in detail based on conventions presented in Jefferson (1974; see the Appendix for the transcription conventions used for this article). Once the visits were transcribed, analysis was undertaken using the techniques and principles of conversation analysis (Sacks, Schegloff, & Jefferson, 1974), an "analytic technology" (Heritage, 1988) for unpacking the sequential and substantive organization of stretches of talk. This approach privileges the finely detailed, empirically verifiable aspects of talk-in-interaction. Within this framework, sequential organization is a central concern (Sacks et al., 1974; Schegloff & Sacks, 1973).

Given the constraint on analysis that calls for strict attention to adjacent utterances, context is understood as locally constructed, that is, as something shaped through unfolding participant talk and action (see also Pomerantz & Fehr, 1997; Schegloff, 1992, 1997); analysts thus refrain from presupposing that any particular construct (e.g., power or gender) is shaping the talk. The interaction itself reveals what information, stances, and concerns are relevant to the participants. Thus, the key advantage of conversation analysis is that analyses are based on how the parties to the interaction demonstrably treat each others' talk and actions (Sacks et al., 1974). The analysis does not focus on what interactants may intend to convey by their talk, but on what the parties to the interaction treat as having been conveyed. Thus, this method has unique validity for analyzing interaction. The meaning of a patient's utterance or a physician's response is revealed through "direct examination of *what happened before* and *what followed next*" in the sequence of talk (Psathas, 1995, p. 48), revealing recurrent patterns and highlighting problematic or disrupted patterns.

FINDINGS

Medical recommendations appear to be accountable phenomena; that is, interactional work is routinely produced that explains or provides support for particular courses of action. These accounts work both prospectively and retrospectively, providing topical and structural framing for and understanding of either what is to come or what has happened. That medical recommendations require such

²The audiotaped oncology clinic visits were collected by Laura Siminoff as described in Siminoff (1987) and in a series of studies by Siminoff and colleagues (Siminoff, 1991; Siminoff & Fetting, 1989; Siminoff, Fetting, & Abeloff, 1989). Briefly, 93% ($n = 100$) of the breast cancer patients approached (sequentially) by Siminoff consented to have their visit with the oncologist tape recorded while Siminoff or her assistant was in the room.

justification is apparent not only from the structure and content of the talk surrounding the recommendation (see Costello, 1990; Roberts, 1999), but also importantly, from the fact that it is something that is oriented to by the physician as a feature of providing a recommendation. Excerpt 1 presents this quite clearly. (See Appendix A for transcription symbols.)

Excerpt 1:

- 1 DR 4: The: the bottom li:ne of my recommendation would be
to
2 add chemotherapy. To the tamoxifen.
3 (2.5)
4 And, having said that, let me go back and *uh try and
5 justify that recommendation for you.*

Here, the doctor characterizes the justification as something that would normally precede his recommendation because in line 4 he says that he will "go back" to try to do just that. The orientation to justifying (or prejustifying) a recommendation is not always this explicit; instead, recommendations are often built up from accounts embedded within the talk and provide the rationale for pursuing treatment. In effect, the justification or accounting actions can be seen as conversational work that is done to get the patient on board with the recommendation. As the account or justification is built and the recommendation is formulated, patients respond by either ratifying or resisting a treatment approach or the rationale or evidence that is being used to build the account.

In the following discussion of exemplars, we will begin with instances of patients agreeing with recommendations. This will set up a contrast with subsequent examples in which patients' responses to recommendations occasion reformulation by the physician.

Responses That Constitute Acceptance of Stated Recommendations

We find that, in certain instances, patients agree unconditionally with the physician's treatment recommendation. Thus, the patient displays agency by ratifying the suggestion and letting it stand, providing on-record assent to the physician's proposal. In the following, the physician suggests that the patient try taking stool softeners to help relieve constipation. In lines 1 and 2 he proposes writing the prescription for the medication.

Excerpt 2:

- 1 DR 3: Ah: withOUT- without really any HARM (.6) u:m .hhh
uw- Why

- 2 don't I- why don't I write a prescription er JIS- t for that.
 3 PT 7: tch oka:y.
 4 DR 3: a:nd you can u:h [()]
 5 PT 7: [Okay. Fine]
 6 DR 3: you can TRY THEM see if they can- see if they're *eh
 uh*
 7 adequate (.) fer yer needs in terms of the (.7) um *e:h in
 ter*- of
 8 TAKing the place of the mineral oil.
 9 PT 7: Okay?

The proposed prescription in line 2 fits with the physician's earlier suggestion (data not shown) that the patient try stool softeners. The patient agrees to the suggestion (line 3) and in overlapping talk she again agrees (line 5). The prosodic quality of the upward intonation of her "okay?" utterance at line 9 is also hearable as agreement; she displays no reluctance and is apparently in accord with the treatment plan. These "okays" appear to be "free-standing receipt markers" (Beach, 1993) in that they mark acknowledgment or agreement. The physician does not alter the trajectory of his talk and simply treats these as continuers. Thus, these conversational moves point to the patient's acceptance of the suggestion of trying stool softeners, or at least agreement to accept the prescription.

Her responses are not only substantive agreement, but also structural agreement: Sequentially they are placed directly after the recommendation, without hesitation. As Pomerantz (1984) notes, "In general, agreements are performed with a minimization of gap between the prior turn's completion and the agreement turn's initiation" (p. 65). Indeed, the physician treats the patient's response as an agreement, moving forward to lay out a plan of action in which the patient is to determine if the medication meets her needs (lines 6-8). Importantly, the patient's judgment is called upon to determine whether the treatment works or not (lines 6-7: "you can try them [to] see if they're adequate").

In the oncology clinic data, on-record agreements are not always available for analysis, even though we know from follow-up information that many patients (68%) agreed to the recommended treatment.³ The reasons for not seeing on-re-

³This percentage (68%) reflects the number of women who followed the exact treatment as was recommended by the oncologist. However, it should be noted that Siminoff, Fetting, and Abeloff (1989) report differential (and higher) acceptance rates for the patients in this study when broad categories of "type of treatment" are considered. That is, 98% of patients for whom standard therapy was recommended, took a form of standard therapy. Eighty percent of patients receiving a recommendation for nonstandard therapy took a form of nonstandard therapy. However, only 46% of patients to whom a clinical trial was presented as an option took that option. In other words, if we were to categorize the patients into those who took some form of standard therapy, not simply the exact regimen recommended, the percentage of those following the oncologist's recommendation might actually be higher.

cord agreements can vary: Either the patient is resisting treatment (which is usually apparent in the talk, as we shall see), the physician is not prepared to offer a firm recommendation (he or she needs to consult with colleagues), or the patient says she needs time to consider the options and thus delays her decision. These considerations aside, there are occasions when patients agree to treatment during the course of the clinic visit. The following is such a case (presented in Excerpts 3 and 4), in which treatment is clearly agreed to by the patient and is thus available for analysis.

In this encounter, the oncologist has presented a recommendation for chemotherapy and radiation. The justification leading up to that recommendation, in which the evidence in favor of treatment is presented by the oncologist, spans nearly 16 min. Throughout that monologue, the patient provides continuers and appears to be positively disposed to treatment; she neither questions the recommendation nor the justification leading up to or following it. The recommendation itself comes at the close of the explanation of the rationale for chemotherapy and the detailing of the two options (take no treatment or take chemotherapy.) Finally, the oncologist asks a rhetorical question: "Which one would I recommend? ... My leanings these days are towards giving people in your situation therapy."⁴

Excerpt 3 begins just after the oncologist has given the patient some information about the timing of radiation and has asked the patient if she has any questions; she responds that she wonders if she can be treated closer to home. This implicit acceptance of the recommendation for chemotherapy is followed by explicit acceptance in lines 591 and 592 of Excerpt 3.

⁴In an extended interaction about the risks and benefits of chemotherapy in this patient's particular situation (chemotherapy is not standard therapy in her case) the oncologist comes down on the side of suggesting chemotherapy. While the oncologist is somewhat equivocal about the chemotherapy option, she is more clear that radiation is less negotiable.

DR 6: The alternative is to say, well, (.) ya know I'm worried !too! and uhm, I think that I would like to take a more aggressive approach and I understand that there are risks that associated with chemotherapy but that I think that (.) the benefits in my situation outweigh the risks. Which one would I recommend? [(clears throat)]

PT 60: [m-hm,

DR 6: My (0.7) leanings these days are towards giving people in your situation therapy. Now radiation therapy remains a separate issue. If you decided not to take chemotherapy, then I would have you seen immediately. and talk to them about whether or not they think you need radiation therapy. If you decided to take the chemotherapy, then I would delay that radiation therapy until after the completion of the chemotherapy. Because wh- we usually don't like to give both of them together if we can help it.

P60: m-hm,

D6: Okay?

P60: Okay.

Excerpt 3:

- 1 DR 6: I can think of several people in the (city name)
 2 area that I could phone up and see if they'd be
 3 willing to take you on.
 4 PT 60: Nkay.
 5 DR 6: And see what they have to say about that. Okay?
 6 would that be better for you?=
 7 PT 60: =Yeah. I'm ya know personally (.) ya know would
 8 like to have the treatment,
 9 DR 6: m-hm?=
 10 PT 60: =because it runs in my family,
 11 DR 6: m-hm?

At line 8, the patient expresses her preference for being treated with chemotherapy and then provides an account for that preference: cancer runs in her family (line 10). Toward the end of the consultation, the doctor continues with an endorsement of the patient's choice to be treated (Excerpt 4).

Excerpt 4:

- 125 DR 6: ... And I'll uhm talk to some of my
 126 oncology friends down here and see if I can find
 127 somebody whose (.) thinking is (.) compatible with
 128 yours.
 129 PT 60: m-hm
 .
 .
 143 PT 60: Yeah, I feel I've really feel comfortable about being [treated.
 144 DR 6: [Okay.

In lines 126 to 128, the oncologist treats the patient's choice to pursue further treatment as a rational choice. Note how she proposes finding an oncologist near the patient's home whose thinking is compatible with the patient's. In the talk omitted between lines 129 and 143, the oncologist presents the possibility that the other oncologists to be consulted may not agree to treat the patient and that the patient is welcome to return to this oncologist should she still feel strongly about getting treatment. So it is clearly now the patient's, not the doctor's, preference that is being aligned with and supported. In this way, the decision to pursue chemotherapy has been shifted into the realm of the patient's choice, and the doctor is now in a position to reinforce that. By taking the opportunity to frame the patient's decision in this way, Doctor 6 is reinforcing the patient's agency in making the final decision about treatment, and the agreement between the participants seems complete.

Patient Responses That Elicit Reformulation of the Recommendation

Reformulation of a recommendation can be occasioned by incipient disagreement. In other words, in cases in which physicians may sense some resistance to a particular recommendation, they might actually back down from it. The implication is that recommendations are not simply unilaterally offered and accepted (or rebuffed), but are proposals that are available for assessment, ratification, and disagreement. As Pomerantz (1984) has shown in ordinary conversation, there is a preference for agreement among participants, and "weak" agreements are treated as potential signals of disagreement. She demonstrates that they can work to open a space in which a subsequent action turns the potentiality of disagreement into agreement. In the following excerpts, it is clear that the physician attends to the display of weak agreement from a patient by reformulating the recommendation or pursuing agreement in some way.

In Excerpt 5, the physician uses a temporal comparison to point out the stability of the patient's condition, noting that there has been no escalation or worsening of symptoms. This premise warrants the doctor's subsequent recommendation to return to the physician who originally treated the condition, a suggestion that is only mildly agreed to; the subsequent reformulation by the doctor, that the patient could also see one of the associates of the original doctor, is the recommendation that is met with stronger uptake. Excerpt 5 demonstrates patient incipient disagreement both with the physician's assessment of her health and with the recommendation he makes. Following her weak agreement with his recommendation, the physician moves to reformulate it.

Excerpt 5:

- 1 DR 1: but Ann *ya know* this hasn't gotten any WORs:e for a
Year or two
- 2 PT 3: Ya I [think yer probably right
- 3 DR 1: [Do you agree.
- 4 That's really a good SI:gn Ann
- 5 (1.2)
- 6 least as far as your LIFE is concerned
- 7 PT 3: hhhuh
- 8 DR 1: an
- 9 (2.2)
- 10 DR 1: I think I'm gunna oo um:
- 11 (1.9)
- 12 [recommend
- 13 PT 3: [*can I put my gloves back on*

- 14 DR 1: Yes: (.) I'm gunna recommend that you: go back n see
Doctor C
- 15 PT 3: *oka:[y]*
- 16 DR 1: OR [one of his associates
- 17 PT 3: oKAY

Following the physician's positive assessment (line 1) that the patient's condition has not worsened, the patient offers agreement in line 2, which in fact overlaps the doctor's probing for her reaction. This collaboration allows the doctor to see that his assessment can stand and permits continuation of the account in lines 4 to 6. Here the doctor offers an assessment that the stability of the situation is "really a good sign." The patient's silence at line 5 could potentially mark her withholding of disagreement with his assessment (Pomerantz, 1984), and indeed the physician orients to this as such by downgrading the assessment slightly to "least as far as your life is concerned." The patient offers a minimal response (a "continuer"), and the doctor proceeds to his recommendation for the patient to return to Doctor C (line 14).

The recommendation is met with an "okay" response presented in a quiet voice (line 15). The physician's uptake of this response is to offer an alternative ("or one of his associates" at line 16), thus displaying an orientation to the patient's prior "okay" as marking something problematic. When the physician offers the alternative of seeing one of the associates of Dr. C, this is met by a stronger delivery of agreement by the patient (the louder "okay" in line 17). Indeed, as this sequence continues, the patient reveals that she was not, in fact, happy with Doctor C.

In summary, this patient provides delayed and minimal uptake of the physician's assessment (that her condition's not worsening is "a good sign"), and she displays little enthusiasm for seeing Doctor C again. Her first delayed response to his assessment evokes a refocusing of his assessment in pursuit of agreement; then, her mild agreement to seeing Dr. C elicits a further alternative that she can see one of Dr. C's associates. Although the patient provides an apparent token of agreement (weakly voiced "okay"), the physician orients to this as a weak agreement, as evidenced in his reformulation of the recommendation.

In another example of reformulation of a recommendation, Excerpt 6 presents an interaction in which the physician refers to the suggestion of another doctor that the patient take a particular medication in a certain way. As noted by Clayman (1988, 1992), third party references in news interviews work to refer responsibility to another speaker or source of information. In a similar way, by referring to a third party, the physician manages to maintain neutrality regarding the recommendation; this opens a space for the patient to present her preference without having to contradict or disagree with the copresent doctor. As seen in the following, the recommendation is met with silence. (Further evidence for what appears to be the pa-

tient's incipient disagreement is presented later, in Excerpt 8, where she presents a counterproposal to the dosing of the medication.)

Excerpt 6:

- 1 DR 1: .hhh I- k=he recommended cholestyramine uh half
pa:cket, (0.2) three
2 times a day.
3 (0.2)
4 That was the original recommendation.
5 (4.0)
6 So: I think you should try tuh work up to it.
7 (0.5)
8 If you can.

In the first line, the doctor is about to present the recommendation as his own, but then reframes it as the proposal of another physician (which it is). Although there is a space for the patient to take a turn during the silence at line 3, she does not. The doctor continues (line 4), not with a reformulation in response to her silence, but simply by linking the "half packet, three times a day" to the "original recommendation." The silence at line 5 is rather pronounced relative to the surrounding talk (the doctor may be reading the chart); nonetheless, with no response from the patient, the doctor continues by reducing the original recommendation to something that could be "work[ed] up to" (line 6). Another brief silence at line 7 is followed by a further mitigation of the recommendation, that is, to work up to the original recommendation if the patient feels she can (line 8).

It appears that the doctor treats the silences at lines 3, 5, and 7 as implicative of resistance or withheld disagreement. Silences of this type have been shown to be displays of resistance in other institutional settings, such as courtrooms (Maynard, 1984), and in the presentation of bad news in a clinic for the treatment of developmental disabilities (Maynard, 1989). As noted earlier, in ordinary conversation, both Pomerantz (1984) and Davidson (1984) suggest that silence may be taken to display disagreement with assessments or rejection of invitations. Thus, at line 6, in presenting the course of treatment as something difficult, something to be worked up to, the doctor downgrades the original third party proposal and displays sensitivity to this patient's apparent resistance to taking the medicine as originally recommended.

In the next example (Excerpt 7), the physician first provides an account for the recommendation to have the gallbladder removed. This recommendation is subsequently modified in the presence of patient response; as in Excerpt 5, the recommendation is met with silence. So what starts as a recommendation for having the gallbladder removed—the doctor uses the "usual case" scenario, which elicits the patient's response to such a procedure—ends up as a recommendation simply to "think about" the possibility of surgery.

Excerpt 7:

- 1 DR 4: So what we Do: is in people like yerSELF we recom-
mend
2 .hhh when yer NO:t having any trouble with the GAll
bladder
3 and when yer in (.5) as BEST a HEALth as you can Be::
4 PT 10: *um*
5 DR 4: thatcha GO Ahead and have the gallbladder removed
6 (3.1)
7 PT 10: *um*
8 ((Patient taps desk and both drop gaze))
9 (2.3)
10 DR 4: So what I would (.2) recommend is this. You think about
it
11 some More?

The silences at lines 6 and 9 and the loss of eye contact (line 8) can be indications of disagreement or potential rejection on the part of the patient (see Davidson, 1984, on offers being reexamined after silence). The doctor's orientation to something problematic in the recommendation is apparent in that it is downgraded by recommending that the patient think the matter over (lines 10–11).

Counterproposal as Strong Disagreement

So far we have seen that recommendations that are revised or amended by physicians come in response to indications of withheld disagreement by the patient (such as silences and hesitation or weak markers of agreement) and work to elicit a reformulation, downgrading, or subsequent version. In this section, we look at instances in which patient opposition to a recommendation is clear and "on record" through their presentation of counterproposals.

It was proposed in the discussion of Excerpt 6 (the recommendation for cholestyramine) that the physician treats the patient's silence as potential disagreement with his recommendation. As the talk continues, the patient's response is indeed one of disagreement in which a counterproposal is offered.

Excerpt 8 (continuation of Excerpt 6):

- 6 DR 1: So: I think you should try tuh work up to it.
7 (0.5)
8 If you can.
9 PT 3: .hh I'd rather do one packet twice uh day.
10 DR 1: That's alright with me:

Here, after another short pause, the physician again downgrades his proposal of "working up to" the recommended dosage by making it contingent on her ability to do so. After the physician animates the patient's agency in deciding what she can tolerate of the medication (line 8), the patient then offers to take the medication twice a day at a higher dosage. This is actually more than was originally recommended for her (see Excerpt 6, line 1). The physician displays no resistance to that and the topic is closed (line 10).

In the oncology setting, when patients resist the recommendation for adjuvant therapy, the physician is less apt to alter it—even when the patient offers some counterevidence. This is because treatment for cancer is standardized, and oncologists have little latitude to fine-tune the particulars of the actual treatment package. In cancer care, when there is a definable disease (as measured by the extent of disease, size of tumor, and lymph node involvement), the medication and dosing is standardized, not a decision-making process of how to approach an individual patient. Thus, patients either accept or reject particular treatment options as a whole, not the particulars of dosing, timing, and so on (as we have seen they may do with other types of medical interventions). What is important to note is that patients do not simply accept the oncologist's expertise regarding the treatment option. In the case we examine in Excerpts 9 and 10, the patient repeatedly interrogates the specialist, moving him to present further clarification on the source of his information. This is a particularly interesting case because it underscores how patient preferences can also be driving the bias outcomes that are evident in the cancer treatment literature.

Just prior to the transcribed talk in Excerpt 9, the doctor stated his recommendation for chemotherapy and then went on to justify it (much of that talk has been deleted here). In Excerpt 9, we see that the patient specifically objects to his claim that there is evidence to support using chemotherapy in women past menopause (lines 11–13).

Excerpt 9:

- 1 DR 4: Uhm,
 2 (1.0)
 3 now it's true that combination chemotherapy is not
 4 standard therapy. Uhhhm,
 5 (1.0)
 6 but there are hhh uh some- there is some
 7 evidence that uh regimens with adriamycin in them
 8 (.) are helpful even in women, uh (.) *uh past
 9 their menopause.*
 10 (0.5)
 11 PT 70: Well ih it they did say that it was not helpful.
 12 Eh eh as tha- such a small percentage (.) *(was

13 helpful).*

Immediately following this, the doctor begins an extended turn⁵ by offering a qualified agreement with what the patient has just noted, but then counters her objection with an explanation of findings that were presented at a national oncology meeting. The conversational resource of partial agreement allows for consideration of the patient's objection while still moving his own point of view forward.

As the talk continues, however, Patient 70 raises further objections to chemotherapy, again by reporting on a conversation with another doctor who was "absolutely" against such treatment. She continues (Excerpt 10) with specific concerns about side effects.

Excerpt 10:

96 PT 70: He ALSO said that uh there the drastic side effects of
chemotherapy, uh
97 at my age sometimes was uh very drastic. And leukemic
(.) uh (.) type
98 things and ↑pain and death. ↑
99 DR 4: Hu weh CHANCES OF of of you developing leukemia
from your
100 chemotherapy are exceedingly small. I mean (.) infinitesi-
mally small. The

⁵ The evidence for the oncologist's "partial agreement" and the advancement of his point of view is apparent in the following excerpt. (The full interaction between Patient 70 and Doctor 4 is discussed in detail with transcribed excerpts in Roberts, 1999.)

224 DR 4: Uhhh the therapies that have been tried (.) to
225 date (.) that uh completed data sets that were
226 available uhm for the consensus conference, I
227 agree. Standard therapy, in fact the standard
228 regimen that we give young women (.) is not
229 helpful (in) older women. But uhhh (.) uh for
230 example, uh there was a (.) paper at the national
231 meetings last year, that was presented in a
232 plenary session.= +now what that means that people
233 thought this was an important enough paper that it
234 was presented at a session where everybody+ (.)
235 uh, attended, uhhh looked at (.) uhhh a standard-
236 compared a standard form of adjuvant therapy, to a
237 standard form with an adriamycin combination added
238 to it. And (.) I think one of the most (..)

- 101 chances of you dying from your adjuvant therapy are (.
aw almost as
102 small.

Here, in lines 99 to 102, the doctor responds to the patient's concern about side effects, mentioning some informal statistics regarding the chances of developing leukemia or dying from chemotherapy. The talk continues for about 5 min with further questions from the patient and explanations from the doctor. Ultimately, in a final attempt to convince the patient of the correctness of his recommendation, the doctor raises the stakes by invoking the roles of doctor and patient. He points to the fact that the patient *asked* for his recommendation. Although the physician has made a vigorous effort to convince the patient of the correctness and even farsightedness of his recommendation, he does not persuade the patient, and she does not choose the treatment that he recommends.

DISCUSSION AND CONCLUSIONS

In the introduction, we claimed that medical recommendations are instances of jointly produced social action in which everyday language practices work to maximize agreement. Drawing on findings from investigations of everyday conversation, it was noted that the mechanisms for minimizing disagreement (such as displays of incipient disagreement and reformulation of proposals) are also operative in medical encounters. In the pursuit of agreement, physicians and patients employ the practices of everyday talk to arrive at negotiated treatment plans. Thus, patients' agency is clearly operative in these data.

In the general medicine clinic, patient response to the justification and delivery of recommendations—whether agreement, weak agreement, silence, or counterproposal—helped to determine what the final version of the recommendation would be and, thereby, the course of action to be followed. In the cases of patient resistance (or counterproposals), recommendations were subsequently reformulated or the counterproposal was ratified.

In the oncology setting, however, recommendations were not reformulated; patient resistance to a treatment proposal was met with further evidence and attempts to persuade. In oncology, treatments are usually protocol driven and therefore not particularly flexible; straying from the protocol would constitute straying from the standard of care. Thus, the choice that patients can exercise usually involves either accepting a therapy as described or not accepting it—that constitutes agency in these situations. Importantly, we saw clear evidence in Excerpts 8 and 9 that patients may actively refute or undermine evidence presented by a physician. This observation provides new insight and directions for thinking about the complexity of sources contributing to treatment bias.

It is important to understand that the active coparticipation of the patient is not just limited to cases in which they make counterproposals or receive recommendations with forms of disagreement. Because patients also actively ratify recommendations, cases of agreement likewise involve the joint interactional work of the doctor and the patient. The cases of agreement analyzed here show patients meeting the doctors' recommendations with verbal assents to treatment plans; nonetheless, it is plausible that, as seen in some excerpts presented here, patients could have met the recommendations with counterproposals or weaker forms of disagreement. Either of these could have led to sequentially and substantively different outcomes. Had the patients made counterproposals, they may have become the course of action to be agreed upon. Thus, a patient's active participation in the development of a treatment plan can take the form of either agreement or disagreement.

Instances of receipt, whether agreement, weak agreement, silence, or counterproposal, all exhibit the agency of the patient in negotiation of treatment plans. If the data show treatment outcomes to be achieved through the joint interactional work of doctor and patient, the traditional Parsonian theory that the physician-patient relationship consists of an institutionalized role set in which doctors are necessarily powerful and patients are not (Parsons, 1951) is called into question. In other words, these data suggest that patients are active participants in formulating aspects of their treatment. Though treatment plans are less negotiable in the oncology setting, it is still clear that patients can and do make attempts to refute evidence presented by the physician, invoking the authority of parties not present.

This type of detailed analysis is crucial in helping us to understand the observable outcome of treatment bias and militates for more careful examination of talk-in-interaction—which is the locus of medical activity. Such analysis provides not only insight into the negotiation of treatment plans, but also indicates how such activities may be related to issues of physician-patient asymmetry and related "face" concerns. Goffman (1955) suggested that social participants are oriented to protecting social situations. He provided the theoretical framework of "face-work" to denote the interactional work members engage in that leads to tactful behavior on the one hand (saving the other's face) and monitoring one's own actions on the other (saving one's own face). The data presented here provide an empirical framework for understanding this notion in the context of medical interactions; it appears that both doctors and patients are engaged in doing work to maintain both their own faces and that of the other, as evidenced through their orientation to incipient disagreement and avoidance of it. By being alert to patient reluctance to accept a proposal and by reforming their recommendations, doctors are protecting their own faces (avoiding refusal) and protecting the patient's face (offering more palatable alternatives with which the patient can agree). Patients deploy the resources of weak agreement and even silence to display resistance to a proposal without having to refuse it outright. This allows them to avoid threatening the phy-

sician's autonomy and to save their own faces by not engaging in overt disagreement. In those examples in which counterproposals are offered by the patient or evidence is marshaled to refute a physician's claim, such "face-threatening acts" are minimized by the physician's either agreeing with the patient's proposal or displaying initial agreement and then providing counterevidence or justification.

In summary, the theoretical face-work framework offered by Goffman (1955) is empirically explicated in the details of the talk examined here. The implication is that power relations in physician-patient interaction may not be operative a priori in medical interactions. Participants are creating contexts of interaction as they go, orienting to the special demands of the professional setting while still having to handle the everyday concerns of agreeing and disagreeing in the usual way. Thus, when we consider the problem of treatment bias we can no longer assume that this is just a "doctor's problem"—this is a problem that both patients and doctors are in the midst of solving as they go about the business of working through the demands of face-to-face interaction.

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APPENDIX A
Transcription Symbols

.	Falling, final intonation as at the end of a sentence.
,	Continuing, comma intonation as in speaking a list
?	Rising intonation
:	Sound stretch; usually elongation of a vowel
CAPS	Louder than surrounding talk
**	Reduced volume between these signs
++	Faster speech between these signs
<u> </u>	(Underline) Stressed element
↑↑	Speech between these signs is hearable as higher in pitch
(.)	Untimed micropause (less than half of a second)
(1.0)	Timed pause, represented in seconds
=	Talk that is latched, quick continuation, no pause between the utterances.
[Marks onset of overlap
-	(Hyphen) Speaker cuts own speech
()	Transcriber doubt
((sniff))	Untranscribed sound
...	(Horizontal or vertical) Ellipsis
