Three-party interactions between neurologists, patients and their companions in the seizure clinic.

By

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ABSTRACT

When patients attend seizure clinics, they are advised to bring along a companion (usually a family member or friend) who can help them to answer questions about their condition. Despite their role being officially sanctioned, there has been some debate over the usefulness of companions in this environment, with some seeing them as eating into the time that patients have to provide diagnostically-important information (Robson, Drew, & Reuber, 2013; Schwabe, Reuber, Schöndienst, & Gülich, 2008), whilst others suggest that companions' contributions may actually help with diagnosis (Robson, Drew, & Reuber, 2016). Research from other medical contexts, meanwhile, suggests that companions can be helpful in ways that go beyond diagnosis, and that these other functions should be taken into account when considering their role in the consultation room (Ellingson, 2002; Laidsaar-Powell et al., 2013).

This thesis aims to build upon this work by examining the companion's role at all stages (beyond just diagnosis and history-taking) in seizure clinic interactions. Based on 30 video-recorded initial visits in a seizure clinic in which a companion was present, my research used conversation analysis (CA) to examine, across four analytic chapters, several aspects of this topic.

In chapter 3 I examine how it is that companions actually come to contribute to these interactions in the first place. My analysis shows that companions were explicitly invited to contribute in 20% of these cases (n=406), were implicitly invited to contribute in 27.6% of these cases (n=553), and that they volunteered themselves to contribute in the remaining 42.6% of cases (n=854). The second part of the chapter then analyses some of these instances in detail. It shows how companion participation is co-constructed between the participants and how companions are attuned to the relevance of their contributions for the ongoing interaction, as well as maintaining an orientation to the patient's rights as primary respondent.

Having delineated the basic means of companion participation, the next two chapters consider how companions can contribute to the medical outcomes of the consultation, in their role as information-providers. Chapter 4 considers how companions can correct patients' accounts of their illness. It shows, specifically how these corrections often upgrade the severity of the patient's own descriptions (e.g. provide a symptom, after the patient has given

a no symptom answer, or upgrade the frequency of how many attacks the patient describes having).

Chapter 5 then discusses companions' contributions to talk, specifically about medication in both the history-taking and treatment-recommendation phases of the consultation. Based on the observation that companions contributed at least once to medication discussions in 67% of cases (n=20) in the data, the chapter shows that, during the history-taking phase, companions were used as an informational resource by both patient and doctor. In the treatment recommendation phase, meanwhile, companions showed initiative in asking questions, making suggestions, expressing concerns, and complaining about medication.

In chapter 6 I demonstrate that companions contribute in a way that goes beyond simply providing medical information, by emotionally supporting patients. It shows that one important way in which they do so is by touching patients at points where they are displaying difficulty or emotional distress. This chapter will discuss how these touches appear to occur systematically in a sequential context where there is something delicate being discussed.

This thesis provides an overview of companion participation in the seizure clinic. It shows how companions can, as expected, act as information-providers, thus supporting previous research (Ellingson, 2002; Laidsaar-Powell et al., 2013; Wolff et al., 2016). It also goes beyond this, though, to show how companions can provide a form of interpersonal emotional support which, while not necessarily part of their 'official' role in the consultation, nonetheless serves an important function. Companions thus contribute at all points in seizure clinic interactions.

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CHAPTER 1 INTRODUCTION AND METHODS

1 Introduction

When patients are invited to attend their initial seizure clinic appointment, they are routinely advised and encouraged to bring someone with them who has witnessed the seizure. This person is usually a spouse, parent, or adult child. This means that a third party being present in the consultation room is a common, accepted feature of seizure clinic interactions.

Despite this, there is some concern that companions might be more disruptive than they are useful in this environment. Robson, Drew, and Reuber (2013), for example, found that when a patient was accompanied by a companion, they spoke less than when they were unaccompanied. While this might not, on the face of it, seem particularly problematic (companions are presumably providing relevant information, after all), consider another body of research (Robson, Drew, Walker, & Reuber, 2012; Schwabe et al., 2008) suggesting that the way in which patients talk about their seizures in initial consultations with neurologists can be used as a diagnostic tool to distinguish between epileptic and non-epileptic seizures (NES). This research has found that patients with epileptic seizures tend to give coherent accounts of individual seizures, relate subjective seizure experiences, and use consistent metaphoric conceptualizations of seizures. Patients with NES, in contrast, tend to give subjective seizure symptoms, and describe their seizures in a way that is both difficult to understand and inconsistent with their choice of metaphors (Schwabe et al., 2008). NES patients also tend to catastrophize when describing their seizures, while patients with epileptic tend to describe them in a way that normalised them (Robson, et a., 2012).

Therefore, if the way in which patients talk about their seizures (their 'communication profile' (Schwabe et al., 2008)) can shed light on the type of seizures that they have, a companion who prevents them from doing so is, from a clinical perspective, a potentially disruptive presence. This is of very real consequence, for two reasons. First of all, making a definitive differential diagnosis using alternative tests can be difficult and unreliable (Schwabe et al., 2008). This means that the consultation may be one of the few chances that doctors have to get an insight into the nature of the patient's condition. Furthermore, epileptic seizures and NES require completely different treatments (anti-epileptic drugs and psychotherapy, respectively) that, if administered incorrectly, can be both ineffective and have unpleasant side effects for patients.

More recent research has shown, though, that such concerns may be unfounded, and that companions may in fact reflect patients' communication profiles. This can be seen in

Robson et al., (2016) who found that that the contributions of companions accompanying NES patients tended to be in response to patients resistance to providing more information about their seizure experience. In other words, the diagnostic potential of patients' talk is also found in the way companions respond to the patients' talk, thus nullifying any deleterious effect that may come from the latter reducing the former's speaking time.

Other research, meanwhile, has shown that companions' potential influence on and contributions to consultations goes beyond simply helping to diagnose the patient (M. L. Clayman, Roter, Wissow, & Bandeen-Roche, 2005; Ellingson, 2002; Kausar, Ambreen, & Andrades, 2013; Laidsaar-Powell et al., 2013; Schilling et al., 2002; Shields et al., 2005; Street & Gordon, 2008; Wolff, Roter, et al., 2012). Several studies have examined the role of companions within different medical contexts, Across these studies companions were identified as playing a role in information exchange, often facilitating understanding between doctors and patients and raising their own concerns (M. L. Clayman et al., 2005; Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Schilling et al., 2002; Wolff & Roter, 2008). Companions are also described as providing company and emotional support (Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Schilling et al., 2002), Facilitating and participating in decision making, and providing functional support to patients with disabilities (Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013). Ellingson (2002) also noted companions can be record keepers in consultations, taking carrying notes. Companions may also be disruptive; Clayman et al. (2005) noted that while companions exhibited many behaviors which enhanced patient autonomy in decision-making (such as facilitating mutual understanding and facilitating patient involvement), they also exhibited behaviors that detracted from patient autonomy (such as controlling the patient and building alliances with the physician). These studies (and others that will be described in more depth) highlight the likely impact of the companion's influence on the consultation.

Companions in seizure clinic interactions may, therefore, be helpful or disruptive in multiple ways, to both the doctor and the patient. Given this potential impact, is important to understand the nature of the companion's role in this environment. The aim and research direction of this thesis, then, is to use conversation analysis (CA) on a set of video-recorded seizure clinic consultations to examine in depth both how it is that companions come to contribute to these interactions and the form that their contributions actually take. This will expand our understanding of three-party consultations both within the seizure clinic and in medical interaction more generally.

I will discuss my aim and research direction in greater depth at the end of this chapter. Before doing so, however, I will provide an overview of my thesis and introduce my methodology.

2 Chapter Summaries

Chapter 1: Introduction. This chapter covers the background for this research project and its aim: to study companion participation and contribution to seizure clinic interactions. The next section, methodology, outlines the data for this project, discusses ethical considerations, and gives some demographics information about the participants. It then discusses and evaluates the two main methods used in this thesis (CA and CA-informed coding).

Chapter 2: Three-party communication in medical consultations: A literature review. This chapter reviews the existing literature on three-party medical interaction. It discusses the broad themes of this literature, including the companion's role, participation, communication dynamics, helpfulness, effect on diagnosis, and issues around autonomy and patient-centeredness. It also covers some of the overall findings of the current research literature.

Chapter 3: Companion participation in the seizure clinic. The first analytic chapter uses a combination of coding and CA to examine how companions come to participate in seizure clinic consultations. Coding is first be used to form an overall picture of the number of companion contributions in the data and how these contributions were occasioned (i.e. was the companion invited to contribute, or did they volunteer to do so?). The chapter then examines in greater depth some examples of both invited and volunteered companion contributions, thus providing a broad overview of companion participation in the data.

Chapter 4: Upgrading corrections. This chapter examines a recurring pattern in the data. This pattern involves the doctor asking the patient a question, the patient answering that question, and the companion coming in to 'correct' that answer, typically by offering either an alternative account, or by modifying the patient's account in a way that upgrades the severity of what they described. This chapter shows that companions can offer alternative versions of events that, had they not been present, the doctor would not have had access to.

Chapter 5: Companion's contribution to medication discussions. This chapter is based on an observation that companions frequently participated in and contributed to discussions about medication. It is divided into two main sections, the first focusing on companions' contributions to the history-taking phase, where they act as an informational resource about the patient's medication upon which both the patient themselves and the doctor can draw. The

second section concerns how companions can both initiate talk and act as a surrogate for the patient by asking questions and making decisions in the treatment recommendation stage of the consultation. This chapter highlights, therefore, how companions can have both an informational and facilitative role when it comes to patients' medication.

Chapter 6: Supportive touching during delicate interactional environments. The final analytic chapter will examine four cases from the data in which the companion touches the patient. These touches occur at points where the patient is revealing something personal or awkward. As such, they seem to perform a supportive role in relation to the delicate nature of such talk. They do so, however, in a way that does not disrupt the project of the "business of the talk." Aside from their utility to the medical goals of the consultation that we saw in previous chapters, then, this chapter highlights how companions can also play an interpersonally supportive role in the seizure clinic.

3 Methods

This section outlines the methods used in this thesis. The first subsection, "Data and ethics", describes how the data were obtained, the ethical considerations of using these data, and the demographics of the participants within the data. The second subsection, "Analytic approach 1: Conversation analysis", describes the main method used to analyse the data (conversation analysis), including its intellectual background, the steps taken in applying it, and the advantages of it. The third subsection, "Analytic approach 2: Coding", describes the secondary method used to analyse the data (coding) and the advantages of doing so.

3.1 Data and ethics

3.1.1 Data

This project used secondary data that had been collected for previous research by Robson (2013). The project and collection of these data arose from Schwabe et al.'s (2008) study (described earlier) of how the linguistic features of patients' accounts can be helpful in distinguishing between non-epileptic and epileptic seizures. Robson's study continued this focus on the diagnostic significance of communication in seizure clinic consultations.

There were two reasons for using secondary data for this thesis, one practical, one theoretical. The practical reason, simply put, is that is saves time and costs, allowing for additional findings to be made without further impacting upon another set of participants. This is particularly important in a clinical environment, where it would be ethically questionable to record fresh data when secondary data are available. Naturally-occurring data

are particularly suited to being recycled in this way because it passes the 'dead researcher test' (i.e. it would have occurred even if the researcher was not present; see (Potter, 2002), meaning that it is less influenced by the researcher's interests than, for example, an interview or questionnaire would be. While there were certainly challenges associated with using secondary data (e.g. lack of ethnographic engagement with the data collection site and lack of control over data and demographic information collection—see section 3.1.4 below), therefore, these were outweighed by the benefits of doing so.

The theoretical reason for using secondary data in this case is that it had not previously been explored in-depth using CA. Robson's (2013) analysis was primarily quantitative, utilising coding and inferential statistics; her use of CA was limited to providing a brief supplement to these findings. My interest, conversely, is to provide a detailed, qualitative analysis of these data supported by basic quantification. The two theses take a different approach to the same data set, taking full advantage of its richness to give a more holistic view of companion participation in these consultations.

Robson (2013) collected the data between January 2010 and March 2012 at a specialist outpatient seizure clinic at the Royal Hallamshire Hospital (Sheffield, UK). As is routine practice (i.e. not part of the study design), all patients were asked, in their invitation letter, to bring along a witness to their attacks if possible. Those that brought someone with them were recorded in the data as accompanied. However, not all the companions that accompanied the patient had witnessed the seizure.

The original study's criteria for patient selection were linked to its aims of researching distinguishing linguistic features between PNES and epileptic seizures (Robson, 2013). For this reason, the study sought patients who were first-time visitors to this particular neurology clinic, and who had been "referred to the clinic because of seizure disorders of uncertain aetiology" (Robson, 2013, p. 12). The study also excluded patients who had learning disabilities, were not fluent in English, or had undergone a major neurological surgical intervention. This information was gathered via patients' medical records before their attendance at the clinic. If it was uncertain whether they should be excluded, they were approached, informed about the study, and the inclusion criteria was discussed and checked.[1]

[1] See Robson (2013) for a more detailed explication of her data collection procedure.

3.1.2 Ethical considerations

As part of the original project, Robson (2013), obtained NHS ethical approval from the South Sheffield NHS Research Ethics Committee. Research Governance approval was also given by The Sheffield Teaching Hospitals NHS trust, and the University of York Ethics Committee cleared NHS approval. Robson was responsible for data collection oversight, including assessing patient's eligibility to participate and obtaining participant (patient and companion) consent. Patients gave consent immediately before the medical consultations. The ethical approval also covered the secondary usage of the data in later projects, including this one.

Permission was given for my research to use the recordings and verbatim transcripts, by Paul Drew and Marcus Reuber, both of whom supervised Robson's project.

For this study, data was stored on a secure hard drive, and care was taken to keep the data and identifying information secure. To protect anonymity, stills from the data have been modified using a filter that only reveals the participants' outlines. Identifying details such as names have also been removed from the transcripts, and any names that appear are pseudonyms.

3.1.3 Reflexive statement

In addition to ethical considerations, it is worth discussing briefly my own relationship to these data. Perhaps the most germane factor here is my family background: I have a sibling with an intellectual disability and have, occasionally, accompanied him on medical visits. This meant that I grew up in a family that was aware of and involved in disability activism.

This thesis does not focus on people with intellectual disabilities, of course. However, my background has instilled in me a set of beliefs about advocacy more generally that could play a role in my analysis. Disability movements do, for example, centralise self-advocacy[2] and emphasise that advocacy should empower the voice and agenda of the person being advocated. These movements also highlight the danger of pushing for an agenda that one believes is in a person's best interests but which in fact goes against them. All of this has made me particularly sympathetic to companions, and aware of the line one must toe between being a supportive and helpful presence for a patient without compromising their dignity and autonomy through unnecessary interference. In other words, I am particularly sensitive to the difficulties of (and pitfalls associated with) the companion role, and this sensitivity could inform my analysis of this role.

[2] This is encapsulated in the mantra, "nothing about us, without us" (see, for example,(Charlton, 1998)).

3.1.4 Participant demographics

The original data consisted of 48 patients. However, for the purposes of this thesis only consultations in which the patient was accompanied (n=32) were included in the study. Two of these 32 cases were further excluded due to the patient displaying marked communication difficulties, either due to not speaking English, or not being able to speak at all. This left a total of 30 cases used in this thesis. (Note that my access to demographic information was limited due, as above, to my using secondary data and not having had control over the information originally collected.)

Table1.1 *The gender of participants*

	Patients	Companions	Neurologists
Men	17	13	3
Women	13	18	0

Of the accompanied patients, there were 17 men and 13 women. There were 18 women companions, compared to 13 men (one male patient was accompanied by both his son and his wife). Each patient met with one of 3 doctors (neurologists) all of whom were male.

Table1.2 *Age range of accompanied patients*

Age	Number of Patients
20-35	11
36-50	9
51-65	6
65+ years	4

All patients were over the age of 18. Ages ranged from 20 to over 65, with most patients being between 20-35 years of age (n=11).

Table1.3 *Patient Diagnosis at 6 month follow-up*

Diagnosis at 6 months follow-up	Number of Patients
EP	12
PNES	12
faint	3
No-Diagnosis	3

An equal number of patients were diagnosed with epileptic seizures (EP, n=12) and non-epileptic seizures (PNES, n=12) in six month follow-up to the recorded consultations, while three patient's attacks were diagnosed as faints. Three patients did not have a confirmed diagnoses 6 months after these recordings took place.

For a case-by-case summary of this information, see appendix D.

3.1.5 Companion Relationship to patient

The following is a table of the types of patient-companion relationship in the data.

Table 1.3 *companion relationship to patient.*

Relationship	Number of companions
Spouse	20
Parent	6
Friend	2
Sibling	1
Adult Child	1
Care worker	1

The majority of companions were the patient's spouses (n=20), six companions were the patient's parent, whilst two were the companion's friend. Three categories are represented by only one companion; sibling, care worker and adult child. The adult child was a son who accompanied his father (the patient) along with his mother (another companion).

It is worth clarifying at this stage the role this information will play in my analysis. As we shall see below, CA as a methodology tends to look more at practices people use in conversation rather than attributing these practices to certain groups of people. For this reason, the companion's identity in relation to the patient (e.g. mother/father, husband/wife, friend etc.) was not in itself a focus. That is, my interest was in the practices associated with the companion role in general rather than distinguishing between the practices used by different types of companion.[3] (Indeed, even if I was interested in this aspect, I would have to consider using a different dataset—the overwhelming preponderance of spousal relationships in this one (n=20) would make it difficult to perform meaningful comparisons.) Now that I

[3] This is not to say that there *were* no differences between different types of companion—only that such differences were not my focus. See the final chapter for more discussion on this.

have established the data that I was using for this thesis, the next subsection will outline the primary analytic method that I used.

3.2 Analytic approach: Conversation analysis

The primary method used to analyse the data for this thesis was conversation analysis (CA). In this section, I will outline the background of CA, how I applied it for the purposes of this thesis, and the advantages of using CA.

3.2.1 Background

As a research methodology, CA analyses the specifics of interaction, such as the sequential structure, design of talk, lexical choice and elements of turn-taking. It was developed by Sacks in collaboration with Schegloff and Jefferson (Heritage & Clayman, 2010; Heritage & Maynard, 2006b).

The basis of CA is to examine the action, context management and intersubjectivity of a turn of talk, and how these elements of the talk are normative practices (Heritage & Clayman, 2010; Heritage & Maynard, 2006b). As a methodology, CA also operates on the idea that interaction is shaped by context and that turns follow a sequence (Heritage, 1984). Preceding turns project one or a range of following turns, and analysis of the action of talk is in part revealed by observing how the participants orientate to this action through subsequent turns (the 'next-turn proof procedure' (Hutchby & Wooffitt, 2008).

CA has been applied to a number of medical contexts, including primary care (Britten, Stevenson, Gafaranga, Barry, & Bradley, 2004; Heritage, 2011; Heritage & Maynard, 2006; Heritage & Robinson, 2006; Raymond, 2014), psychotherapy (Ekberg & LeCouteur, 2015; Thompson & McCabe, 2012), pediatrics (Stivers, 2001), maternity (Tiitinen & Ruusuvuori, 2012), and memory clinics (Elsey et al., 2015; Jones et al., 2016; Larner et al., 2005; Peel, 2015).

The findings from CA studies can have practical implications. For example, one problem identified by primary care doctors in the US is that patients can leave consultations without having mentioned additional concerns that they might have. These concerns are thus left unfulfilled. Heritage and Robinson (2011), however, found that doctors who used the word "some" when soliciting unmet concerns (e.g. "Is there something else?") solicited significantly more than doctors who used the word "any" (e.g. "Is there anything else?").

CA can also be used to explore problems that have wider social implications, such as the over-prescription of antibiotics, by identifying the interactional pressures that lead to them

(Stivers, 2007; Stivers, Mangione-Smith, Elliott, McDonald, & Heritage, 2003). It can also help to deal with these problems by identifying practices (such as 'online commentary') that help to shape patient expectations of a no-problem diagnosis, thus reducing resistance to non-medication solutions (Heritage & Stivers, 1999; Mangione-Smith, Stivers, Elliott, McDonald, & Heritage, 2003). As discussed previously, CA has also been used in seizure clinics to identify diagnostically relevant differences in the communication profiles of patients with epileptic seizures and patients with NES (Robson, 2013; Robson et al., 2012; Schwabe et al., 2008).

CA is, therefore, an established way of analysing medical interaction, with both strong theoretical underpinnings and a history of successful practical application. With this background in place, the next subsection will describe how CA was applied for the purposes of this project

3.2.2 Applying conversation analysis

There were two procedural steps that I took in applying CA for this thesis. The first was to transcribe relevant extracts within the data, and the second was to gather these extracts into collections.

3.2.2.1 Transcription

Individual extracts were transcribed using the conventions developed by Jefferson (2004), which aim to capture not just what was said, but how it was said (e.g. the speaker's intonation), and where it was said (e.g. whether the speaker started talking in overlap with another speaker). Because some of the chapters involved emotional displays, as well, I also used the conventions for capturing emotive voice quality discussed in Hepburn & Bolden (2017).[4]

Two of the chapters in this thesis also considered non-verbal conduct. This was captured in the transcript by using double bracketed comments and screen-shots. Screenshots of non-verbal conduct were incorporated into the transcript using a simplified and adapted version of the style used by Kendrick & Drew (2016). This entailed using a vertical bar symbol (|) to indicate timing that could be cross-referenced with the relevant screenshot. This style of transcript was chosen over incorporating the screenshots into the transcript directly to

[4] For a glossary of transcription symbols used in this thesis, see appendix A.

minimize disruption to the flow of the transcript. Screenshots of the data also used arrows and other markings to emphasise movement, and gaze direction.

3.2.2.2 Building collections

Once multiple instances of a phenomenon (which could be re-occurring sequence or action) had been identified in the data, the next step was to gather these instances together into collections. These collections were transcribed in more detail and analysed further, so as to identify patterns within and around the phenomenon at hand. In some cases, a wider collection was organised into subcategories based on patterns in the data. The 'upgrading corrections' collection (chapter 4, for example, was based on a subcategory from a more general collection of corrections.)

3.2.3 Advantages and disadvantages of using CA

There are several advantages of using CA. One of the advantages stems from CA's use of real-life recordings as data, which allows for a detailed explication of what is going on. CA focuses on observable patterns of conduct, rather than relying on after-the-fact interpretations from participants or observation notes. This focus on naturally-occurring data and the details of interaction means that CA gets closer than any other methodology to exploring precisely how interactions work and what role language plays. In practical terms, this means that practitioners can observe their own practices in CA findings. It also means that CA can provide an insight into effective and ineffective practices based not on assessments of individuals, but on broader patterns of interaction.

It is worth considering CA's relationship with other qualitative methodologies. On the one hand, CA is clearly distinct from approaches such as thematic analysis and grounded theory, both of which are more commonly used with non-naturally-occurring data (e.g. interviews and focus groups) and both of which are more concerned with the *content* of utterances than the social actions that they perform. For these approaches, in other words, language is treated as a window into other issues rather than a focus in itself.

CA's relationship with other discursive approaches is more complicated. CA shares with these approaches a "distinctive... focus on discourse/language use as a topic in its own right" (Wooffitt, 2005, p. 79). Fundamentally, though, CA is concerned with "the social organisation of activities conducted through talk" at the "turn-by-turn" level while discourse analysis more broadly defined is concerned with "the wider interpersonal or social functions served by a passage of talk" (Wooffitt, 2005, p. 79-80). CA has drawn criticism from more

critical researchers for failing to take into account wider socio-political context (Billig, 1999; Schegloff, 1997, 1999; Wetherell, 1998; Wooffitt, 2005).

CA thus has a complex relationship with other methodologies. This does not mean, though, that CA is incompatible with these approaches. For example, researchers have used interviews and other ethnographic methods (e.g. Lutfey & Maynard, 1998) alongside CA to provide a more holistic picture of the institution being studied. CA researchers have also worked closely with institutions, which can itself provide them with a more ethnographic understanding of the data that they collect. This is not to mention the increasing number of researchers (especially in clinical settings) who are using CA alongside quantitative methodologies, taking advantage of its ability to identify and define interactional practices and complementing that with inferential statistics (see, for example, Heritage & Robinson, 2011; Stivers, 2015(J. C. Heritage & Robinson, 2011; Stivers, 2015)).

I myself will be not be taking a strong position on these methodological issues, most of which go beyond the scope of this thesis. Suffice it to say that I regard all methodologies as potentially useful if they are fitted to the aims of the research and that, ultimately, I see CA as the best fit for the topic of this thesis. The advantages are that companions' practices and conduct can be examined within the consultation, exactly how it happens, without relying on observation notes or what participants can remember. Because of this, their conduct can be analysed repeatedly, closely and in finer detail. The companion's roles in the consultation, as suggested in the literature (Cene et al., 2017; Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Schilling et al., 2002), can be observed as they occur in practice. This allows for a more nuanced view of the companion's role grounded in what actually happens. Through video data, and CA's attention to sequence and detail, this method allows the discovery of when and how companions accomplish specific roles in the consultation.

CA analysis can also shed light on the possibility that the presence of companions detracts from patient-centeredness by reducing the amount of time (or words) patients spend talking (Ishikawa, Roter, Yamazaki, & Takayama, 2005; Robson et al., 2013; Shields et al., 2005). CA can examine such concerns by showing, turn-by-turn, the precise way in which companions come to participate, and the nuance in how interlocutors negotiate participation.

CA was, therefore, the primary method used in analysing the data for this thesis. This allowed, as will be clear in the analysis, for an in-depth examination of companion contributions in seizure clinics. However, there were also points at which I needed to obtain a broader, more quantitative overview of these contributions. To this end, I also used a secondary methodology in this thesis: CA-informed coding.

3.3 CA-informed coding

3.3.1 How coding was used

Coding was mainly used in chapter 3 of this thesis to determine what proportion of companion contributions were explicitly or invited through gaze (by either the doctor or the patient), and what percentage were volunteered by companions themselves. CA findings on question design (Clayman & Heritage, 2002; Heritage & Roth, 1995) and speaker-selecting multimodal behaviours such as head-turning (Larner, 2012; Stivers & Rossano, 2010) were used to develop and implement the codes.

3.3.2 Coding procedure

The data were coded using a spreadsheet. Companion's contributions were recorded with the time in the video they occurred and coded for whether they were explicitly invited, invited through gaze, or self-selected. Cases where it was unclear (e.g. when a participant was off-screen, making it impossible to determine their gaze) were marked as such.

There was also room in the spreadsheet for me to write qualitative notes and observations for each instance. These notes included initial observations about actions of the turns, how they came about, and the context of the talk. I also took note of particularly interesting instances in the data. While these observations did not affect the coding, they were helpful in further developing collections and recording possible patterns to investigate with CA in other chapters.

3.3.3 Advantages of using CA-informed coding

Coding the data allows researchers to make claims about the distribution of phenomena that are not as easily made using CA alone (Robinson, 2007; Stivers, 2015). Stivers (2015) argues that CA lends itself well to formal coding because part of the conversation analytic process is to characterise practices and form criteria for inclusion and exclusion. These characterisations of practices included identifying the linguistic form and sequential position of the practices as part of the criteria.(CA often also characterize further subtypes by identifying patterned variations in a broader practice category.)

This thesis used past conversation analytic research on turn-taking and speaker selection (Lerner, 2003; Rossano, 2011; Stivers, 2001; Stivers & Rossano, 2010; Tiitinen & Ruusuvuori, 2012) to inform the coding criteria. The advantage of using coding criteria based

on CA observations in this way is the removal of ambiguity. Since the criteria are based on particular linguistic features (design of the question to select next speaker) or multimodal behaviours (gaze) that are either there not (Stivers, 2015), there is less interpretation needed.

4 Research direction

At the beginning of this chapter, I stated briefly the aim of this thesis: to examine in detail companions' contributions in seizure clinic interactions. Ordinarily, a research aim would be followed by a research question. However, CA as a methodology tends not to have research questions, instead encouraging, in its purest form, 'unmotivated looking' (Have, 2007, p102) grounded in what appears in the data. My reason for not having a formal research question is thus methodological, deriving from CA's inductive tenets.

Despite not having a research question, I did begin this research with a broad focus and *direction* in mind. This arose from clinicians on the project from which the data was taken, who had already suggested the influence of the companion as a potential line for further enquiry (Robson (2013) having touched upon this topic in her analysis). This concern was also implicit in the literature, for example in the number of studies that measure the impact of the companion's presence on participation, patient autonomy and patient centeredness (for example; Cene et al., 2017; Del Piccolo et al., 2014; Dooley, Bailey, & McCabe, 2015; Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Laidsaar-Powell et al., 2013; Robson et al., 2013; Shields et al., 2005). With this in mind, I decided to go into my own analysis with the research direction to examine the role of the companion in seizure clinics.

Despite having this a priori interest, I endeavoured to be as unmotivated as possible when looking at the data. I did not, for example, know ahead of time which *aspects* of the companion role I was going to be looking at. Still, there were additional outside influences, most notably my aforementioned family background and my own personal experiences as a companion, that would naturally colour my analysis. In summary, therefore, my approach was to be unmotivated within the confines of an already-developed research direction and mindful of additional contextual factors that may have had a bearing on my analytic focus and interpretations (as they would with any researcher).

With my methodology and research direction now established, the next chapter will review the existing literature on relevant topics. This will both provide more in-depth background information on the thesis and lay the groundwork for the analytic chapters to follow.

CHAPTER 2 TRIADIC MEDICAL INTERACTIONS: A LITERATURE REVIEW

This chapter will review the existing literature on three-party communication in medical interaction. Before beginning, it is worth establishing which literature will be included and excluded.

First of all, this chapter will not be looking at research on either companions or medical interaction in general. Instead, it will restrict its focus to those studies that fall at the intersection between these two broader fields of knowledge. The reason for this focus is that this thesis does itself fall at this intersection, meaning that this is the literature that will be most relevant to the analysis to come. It also allows this thesis to be placed in the context of wider trends in three-party clinical communication research. Focusing on interactional research also excludes from the discussion research on companions in medicine in general, much of which has a broader focus on the companion's role in contexts other than the immediate interaction (e.g. in patient care).

This review also excludes three-party research in which the third party is a professional such as a nurse (e.g Torppa, Timonen, Keinänen-Kiukaanniemi, Larivaara, & Leiman, 2006), medical student or translator (e.g. C. W. Raymond, 2014a, 2014b). These professionals do, of course, have an official role to play, meaning that their effect on the interaction is likely to be very different from that of a friend or family member with whom the patient has a personal relationship. Given that the analysis will focus exclusively on the latter type of companion, it makes sense for the literature review to reflect this.

The review is structured in ten sections, each covering a recurring theme identified in the literature: research settings, patient characteristics, the role of the companion, information-giving and receiving, participation, turn-taking, communication dynamics, autonomy and patient-centredness, diagnostics and method. The final section ("Summary") brings together the review as a whole and sets up the analysis to follow.

1 Research Settings

Research on 3-party communication in medical contexts has in the past tended to focus on primary care consultations and only recently become more commonly conducted in secondary care contexts. Within primary care settings, the focus of research tended to be paediatric and geriatric populations. Several studies examined third-party interaction only within paediatrics (P. Cahill & Papageorgiou, 2007b, 2007a; Stivers, 2001; Stivers et al., 2003; Tates &

Meeuwesen, 2000; Tates, Meeuwesen, Bensing, & Elbers, 2002). Companions in these studies were typical parents.

Studies that looked at older populations generally focused on “geriatrics” or or an older population that had age related health issues (Adelman, Greene, & Charon, 1987; Beisecker, Chrisman, & Wright, 1997; Clayman, Roter, Wissow, & Bandeen-Roche, 2005; Coe & Prendergast, 1985; Fortinsky, 2001; Ishikawa, Roter, Yamazaki, & Takayama, 2005; Schmidt, Lingler, & Schulz, 2009; Shields et al., 2005; Wolff, Boyd, Gitlin, Bruce, & Roter, 2012; Wolff & Roter, 2008, 2011). Companions in these consultations tended to be the spouse or child of the patient, but patients were also sometimes accompanied by friends.

The reason paediatric and geriatric populations are often the focus of research on third party interaction in medical consultations is that these groups tend more often to be accompanied by companions (Schilling et al., 2002). Moreover, these two population groups are not always isolated from each other in the research, there was also literature that examined the influence and role of companions in both paediatric and geriatric settings in primary care in the same study (Barone, Yoles, & Clair, 1999; Schilling et al., 2002).

In paediatric care, the companions, (parents) are a taken for granted aspect of the encounter. Sometimes this is manifested in the literature by grouping the patient and companion as a patient unit, focusing research on wider issues of medical practice rather than how they dynamic of a triadic consultation affects these groups. For example, Heritage & Stiver’s paper on online commentary as a way to manage patient’s expectations included cases of parent-child-doctor interaction as part of the analysis. In this analysis, the parent and child were both parts of the patient side of the interaction whose expectations were being managed (Heritage & Stivers, 1999). Therefore there is a body of literature that uses third-party interaction as part of its data set but does not focus analysis on the third-party dynamic of the interaction; this kind of research largely has not been included as part of this literature review.

In paediatric research that was concerned with the three-party dynamic of the consultation there was a growing focus on researching the participation, autonomy and role of the child in such consultations (P. Cahill & Papageorgiou, 2007a, 2007b, Tates & Meeuwesen, 2000, 2001; Tates, Meeuwesen, Bensing, et al., 2002; Tates, Meeuwesen, Elbers, & Bensing, 2002; Wassmer et al., 2007). Autonomy and patient centeredness are increasingly important concerns in research where the patients are reaching adolescence (Buchbinder, 2009; van Staa, 2011).

In contrast to research on paediatric third party interactions, research into older patients in primary care tended to treat companions as an additional person to the patient-doctor interaction. Their presence within the consultation is questioned more, and the concerns in the literature tend to focus more on general questions about the role of the companion, how helpful they are and what their impact on the consultation is. This difference between paediatric and older-patient companion research may reflect the general assumption that parents are guardians and decision makers of children's health, while companions in older patient's care fulfil a more background role.

In recent years there has been an increase in research on companions in secondary care, particularly in oncology (Cordella, 2011; Del Piccolo et al., 2014; Eggly et al., 2006; Ellingson, 2002; Labrecque, Blanchard, Ruckdeschel, & Blanchard, 1991; Street & Gordon, 2008), dementia care (Fortinsky, 2001; Fukui, Yamazaki, & Kinno, 2011; Karnieli-Miller, Werner, Neufeld-Kroszynski, & Eidelman, 2012; Larner, 2012; Larner et al., 2005; Sakai & Carpenter, 2011) and a few in seizure clinics(Robson et al., 2013, 2016). Other secondary care contexts include maternity care (Tiitinen & Ruusuvuori, 2012), heart disease (Cene et al., 2017),and Chronic illnesses such as diabetes (Buchbinder, 2009; Pyörälä, 2004), and seizure clinics (Robson et al., 2013, 2016).

In research on companions in secondary care, the contexts are more diverse, and the clustering of research tends to be more around the areas of medicine where patients are more likely to need companions for emotional support (oncology), functional support (dementia) and informational support (dementia, seizure clinics, oncology). The study of companions is also highlighted as important in palliative care, where companions are specifically included in family meetings to discuss the patient's illness and to be present for decision making around end of life plans (P. J. Cahill, Lobb, Sanderson, & Phillips, 2017; Powazki, Walsh, Hauser, & Davis, 2014; Wallace, 2015)

2 Patient characteristics

As previously discussed, patient characteristics such as age feature as an aspect of how the literature is spread over setting. Patient characteristics can also be a variable that is investigated within the research. Companion research sometimes investigates whether a patient's characteristics can predict if they are accompanied, and what these characteristics are (Del Piccolo et al., 2014; Fortinsky, 2001; Labrecque et al., 1991; Shields et al., 2005; Street & Gordon, 2008; Tates & Meeuwesen, 2000; Wolff et al., 2016; Wolff, Boyd, Gitlin, Bruce,

& Roter, 2012; Wolff & Roter, 2008, 2011). Patient characteristics, tend to focus on a gender, sociocultural background, education, and health.

In their systematic review on physician-patient-companion communication Laidsaar-Powell et al.(2013) summarised how the demographics of patients accompanied by a companion differed from unaccompanied patients. Accompanied patients were more likely to be older, female, less educated, and with poorer physical health. Laidsaar-Powell et al. did note that findings differed between studies, especially with demographics such as gender, and the way demographics was found to predict whether a companion was accompanied was more dependant on the type of practice and severity of the health problem.

The characteristics stated above are also slightly variable from setting to setting. The influence of gender, particularly, seems to vary from study to study. For example, although Wolff & Roter (2011) found in their systematic review that accompanied patients were more likely to be female, Ishikawa, Roter et al (2005) found in their study of geriatric primary care encounters in Japan that men were more likely to be accompanied. There were patient characteristics that were similar, such as accompanied patients were often older and had poorer health.

Laidsaar-Powell et al.'s review only looked at contexts with accompanied adults but highlighted that patients in primary care who have increased functional or communicational needs are more likely to bring a companion. For example, in routine visits patients with reduced-competence were more likely to be accompanied. However, this pattern was less present in settings where patients had a severe or chronic illness (oncology) where patients are more likely to be accompanied regardless of these demographic factors.

Patient Characteristics were also often measured in their relation to patient participation. (Del Piccolo et al., 2014; Eggly et al., 2006; Schmidt et al., 2009; Shields et al., 2005; Street & Gordon, 2008; Tates & Meeuwesen, 2000; Wolff & Roter, 2011). These results are somewhat related to the idea that patients with higher need tend to bring a companion. Therefore, it is not surprising that a common finding in the research was that patient's needs, preferences, expectations on the companion's role, predicted patient and companion participation. For example, in Schmidt et al. (2009) study on Alzheimer's patients, a patient's cognitive score (MMSE score, verbal fluency) predicted participation levels of both patients and their companions.

Demographic characteristics such as age (Eggly et al., 2006; Tates & Meeuwesen, 2000), education level (Eggly et al., 2006) and race (Street & Gordon, 2008) have also been reported to having some influence on a patient's level of participation in Triadic medical

encounters. Eggly et al (2006) found that during “bad news” oncology interactions, while most personal and demographic characteristics were unrelated to how many questions patients asked, there was a trend that older patient’s asked fewer questions, and more educated patients asked more questions. In a study by Tates and Meeuwesen (2000), age was also reported as a factor in how much children verbally participated in consultations, and that children participated more in medical encounters as they got older.

Findings on how patient characteristics influence participation paralleled by findings on how patient characteristics influence whether or not a patient is accompanied. The same demographic characteristics have been found to predict whether or not a patient is accompanied by a companion and level of patient involvement. There is research to suggest these two are linked. Del Piccollo et al. (2014), in their study on the effect of companion presence on question-asking in breast cancer consultations, suggested that patients who had a preference for being more passive in decision-making were more likely to be accompanied.

3 Role of the companion

The perceived and enacted role of the companion was another large area of research in triadic medical consultations (Cordella, 2011; Ellingson, 2002; Laidsaar-Powell et al., 2013; Robson et al., 2013; Schilling et al., 2002; Street & Gordon, 2008). Street & Gorden (2008), described the companion in oncology consultations as often playing an observer role in consultations, though companions also sometimes had more active roles including acting as advocate or proxy for the patient. When in a more active role, companions acted primarily as support for the patient, and to provide physicians with additional information.

The most commonly reported roles, according to a systematic review (Laidsaar-Powell et al., 2013), are *emotional support, informational support, facilitating mobility* and *other functional roles*. The emphasis of these roles tends to differ depending on the type of medical consolation. Laidsaar-Powell et al. (2013) observed that the primary roles for companions accompanying patients with chronic illnesses (cancer, diabetes) were emotional support and informational support roles, while the primary roles for companions accompanying geriatric or older patients tended to be logistical and informational support. Research that looks specifically at defining the role of the companion using observational data, rather than questionnaires, has most commonly been conducted in oncology settings.

Ellingson (2002), who specifically studied the role of companions in oncology interactions, identified companions’ roles as including being a memory aid, emotional

support, transcriber, advocate, interpreter, elaborator, companionship and aid in decision making (Ellingson, 2002).

Emotional support was highlighted as being particularly relevant, alongside informational support, in cases of chronic illness, such as diabetes or cancer (Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Street & Gordon, 2008). In her observational study Ellingson (2002) who looked at companions in geriatric oncology, defined *emotional support* as providing social support, and offering empathy. Some examples of verbal support were reassurances of future healing or easing of suffering and companion's continued presence. Non-verbal support included holding hands, putting an arm around the patient's shoulder or offering a tissue. The companion's role as emotional support was also highlighted as providing relief for physicians who were more able to leave a distressed patient to be supported by a companion. Companionship was described as a separate role in comparison to emotional support in Ellington's (2002) study but shares some similarities as providing company to deal with the boredom of waiting and the stressful nature of the visit.

While emotional support often appears in response to questions of what patients, doctors or companions perceive the roles of a companion to be, in comparison to Informational support, emotional support is a much smaller focus in research that details interactional practices in medical encounters.

Facilitating mobility and other functional roles are also mentioned in the literature that looks more generally at the role of companions and reason for the companion's presence. However, these roles are not particularly highlighted in research that has a focus on communication. As highlighted previously in "patient characteristics" patients with higher needs, including poor health, are more likely to be accompanied. Therefore, while not the focus of research on communication, this particular role is often present and enacted in encounters where patients have greater needs (Wolff et al., 2012).

The companion's role in decision-making is also an on-going theme (Ellingson, 2002; Laidsaar-Powell et al., 2013), decision making is often related to informational support as often one of the ways companions facilitate decision-making is by asking questions and repeating relevant information provided by medical practitioners. Ellingson (2002) found that companions frequently tried to clarify information or alleviate concerns to address patients resistance to treatments recommended by a medical practitioner (Ellingson, 2002). In palliative care, the consultations are often designed to include friends and family members in the decision-making process (P. J. Cahill et al., 2017; Kausar et al., 2013). In these family meetings, the goal is to facilitate shared decision-making and improve communication with

families, particularly around end-of-life care. The other area where the companion's role in the decision-making process is most prominent is in paediatrics (Tates & Meeuwesen, 2001). The companion's role in decision-making is often explored in relation to the patient's rights to autonomy, and often when the companion's role in decision-making is mentioned, it is balanced with concerns to protect the patient's voice and autonomy in such discussions. However, in doctor-parent-child interactions, the child's role in decision-making is sometimes overshadowed by the focus on the interaction between the doctor and the parent (Tates & Meeuwesen, 2001).

Advocacy was another role mentioned in research (Beisecker et al., 1997; Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Larner et al., 2005; Street & Gordon, 2008; van Staa, 2011). Advocacy was hypothesised as one of the three main roles a companion played in Adelman et al.'s (1987) proposed a framework, where the companion was either an advocate, a passive participant or an antagonist. In Adelman's definition, the advocate is someone who promotes the patient's agenda, acts as an extension of their voice and tries to bridge the gap between the patient and the physician (Adelman et al., 1987). These hypothesised roles were often discussed as part of the framework other researchers used to examine companion participation roles (Cordella, 2011; Ishikawa, Roter, Yamazaki, & Takayama, 2005). In research more aimed at describing the observed roles of companions, the role of advocacy is described as making requests on the patient's behalf, asking questions about alternative treatments and expressing and supporting patient's unwillingness for certain treatments (M. L. Clayman et al., 2005; Ellingson, 2002).

One of the most widely researched roles of companions is the role of informational support. Informational support comprised of companions facilitating understanding between doctors and patients, answering questions and providing questions themselves.

One of the ways that companions provided informational support is as memory aids, providing prompts and information to patients when patients are struggling to remember (Ellingson, 2002). Companions can also in this role act as 'transcribers', writing down information that arises within the meeting or providing a written record (Ellingson, 2002), thereby helping record and remember information including complex treatment instructions. Companions could also be elaborators; this was cited as different from being memory aids, as often in cases of elaboration the companion would provide some context for patient's comments, rather than aiding in recall. Sometimes these elaborations could contradict the patient's version (Ellingson, 2002).

Informational support also included facilitating understanding patients and doctors, as well as giving and receiving information (Laidsaar-Powell et al., 2013), asking questions and clarifying patients' answers. Related to this is the role of interpreter, as described by Ellingson (2002) where the companion facilitated understanding by repeating information for patients who were hearing impaired or providing language translations. In this role, the companion was also described as re-explaining information from the physician that the patient had misunderstood.

Cordella (2011), who was also investigating the role of companions in oncology, found similar roles to Ellingson (2002). The main two roles they found were companions as "carers" and "health advisers". Other roles included "secretary", "financial assistant", "social communicator" "reporter" and "partner". In their conclusions, they observed that companions in these roles provided valuable information that gave the medical practitioner a more holistic view of the patient's needs and home life. When companions enacted the role of "health adviser" they often provide a great deal of information, and while sometimes this information may be in contradiction to the patient, it can relieve the patient of some of the responsibility in the encounter. Their knowledge denotes the close monitoring of the patient's health outside a medical setting that Cordella reports they regularly exercise (Cordella, 2011).

4 Information-giving and receiving

While also mentioned as a role of the companion, information-giving and receiving was a subject explored in depth in research on companions in medical communication. As a research interest, information-giving and receiving comprise a wider interest in the exchanging and mutual understanding of information between participants in a triadic medical consultation. Information giving and receiving is studied in the literature as a describable and quantifiable behaviour that is used in some literature to measure the value, or extent of a companion's influence in a consultation (Dooley et al., 2015; Ishikawa, Roter, Yamazaki, & Takayama, 2005; Labrecque et al., 1991; Laidsaar-Powell et al., 2013; Street & Gordon, 2008; Wassmer et al., 2007; Wolff et al., 2016; Wolff & Roter, 2011). The information giving and receiving behaviours through asking and answering questions, by patients, companions and doctors respectively, is quantified in order to compare the differences between when a companion is present and when they aren't, or what kind of information companions give.

As has been discussed in the preceding section, companions are often described in the literature as facilitating understanding and providing informational support (Cordella, 2011; Ellingson, 2002; Laidsaar-Powell et al., 2013; Street & Gordon, 2008). Facilitating

understanding and providing informational support is through behaviours discussed under the role of the companion, such as explaining a doctor's turn to a patient, providing information, prompting the patient, elaborating on the patient's turn, or asking questions themselves.In some cases, this informational support when linked to decision-making activity is described as facilitating patient autonomy (M. L. Clayman et al., 2005).

The kind of information companions provide is of interest in this area; in a systematic review by Dooley et al. (2015) on medical interactions in dementia, it was stated that companions often gave more bio-medical information than the patient, and were twice as likely to report dementia-related behaviours. The nature of the difficulties influenced how readily they were expressed. For example, while memory difficulties were more readily discussed, behaviour difficulties like wandering were still underreported. (Dooley et al., 2015) This included asking questions to the medical practitioner or supporting the patient in giving information.

In some medical contexts, the companion is specifically asked to come to provide extra information. One such context is seizure clinics, where patients are asked explicitly in their appointment invitation letter to bring a companion with them, to help in describing a seizure they have witnessed. Companions often describe one to three different seizure events, e.g. the first, worst or most recent seizure they have witnessed as part of the consolation (Robson et al., 2016). The reason for this is that they have primary access to information that the companion, who was unconscious at the time, does not have primary access to. For this reason, while companions are noted to influence information exchange in consultations across a variety of medical contexts, in some areas their involvement may be starker than others.

This research theme also concerns how the presence of the companion influences the physician's and patient's information giving and receiving behaviours (P. Cahill & Papageorgiou, 2007a; Cene et al., 2017; Del Piccolo et al., 2014; Ishikawa, Roter, Yamazaki, & Takayama, 2005; Labrecque et al., 1991; Wolff et al., 2011; Wolff & Roter, 2011). These behaviours are also used in the literature as a way to measure engagement of companions and patients (P. Cahill & Papageorgiou, 2007a, 2007b). More information-giving, in general, is itself seen as a desired outcome, creating a focus on those interactional factors that create an environment in which patients, doctors, and companions provide more information (Wassmer et al., 2007); how much information is shared is often used as a measure or indication of how useful, or otherwise, the presence of a companion is (Wolff & Roter, 2008).

Some of the behaviours studied under this theme are question-asking/information-seeking (Del Piccolo et al., 2014; Eggly et al., 2006), dimensions of these behaviours such as

the frequency, are often used as a measure of engagement of patients, and usefulness of the companion. For example, Del Piccolo et al. (2014) explored whether the presence of a companion influenced Italian breast cancer patient's question asking behaviours in consultations. They found that unaccompanied and accompanied patients asked the same number of questions on average, and socioeconomic factors had a stronger influence on how many questions patient's asked. The presence of the companion increased the number of questions asked in the consultations without suppressing the rate at which patients asked questions. It supported other studies that showed in general physicians provided more information when a companion was present (Del Piccolo et al., 2014; Eggly et al., 2006; Labrecque et al., 1991; Laidsaar-Powell et al., 2013; Wolff et al., 2011)

Several studies focused on how the presence of a companion influences the focus of the information a physician gives and receives. For example, in Wolff & Roter's (2012) study on accompanied older adults in routine visits, they found that in consultations where a companion was present, the patient's engaged in less psychosocial information giving. They also found that patients, companions and doctors tended to focus more on task-oriented and biomedical discussions in accompanied interaction.

5 Participation

Measuring participation was another reoccurring theme in the literature. Participation of companions, patients and doctors were measured in several ways, most commonly through percentages of talk within a consultation (Ishikawa, Roter, Yamazaki, & Takayama, 2005; Shields et al., 2005; Tates & Meeuwesen, 2001), and frequency of engagements in behaviours like asking questions, information giving and decision-making(Del Piccolo et al., 2014; Eggly et al., 2006; Laidsaar-Powell et al., 2013; Tates & Meeuwesen, 2001; Wassmer et al., 2007). Part of the focus of participation is using it to measure if companions have an influence on the level of patient participation, and a concern to keep consultations patient-centred. How the patient participates and the nature of their participation is often related to describing the roles they enact in consultations (Laidsaar-Powell et al., 2013; Powazki et al., 2014).

Understanding the level of patient participation is often cited as important because it is seen as a measure of patient-centeredness. In Ishikawa, Roter et al., (2005) consultations where patients were more verbally active (as calculated by the number of patient utterances divided by a total number of utterances), were rated as more patient-centred by patients.

Percentages of amount of talk are measured in the number of words spoken (Robson et al., 2013; Shields et al., 2005), or the total number of utterances (Ishikawa, Roter, Yamazaki,

Takayama, et al., 2005; Ishikawa, Roter, Yamazaki, & Takayama, 2005). Overall, research has shown that medical practitioners spoke the most, both in accompanied and unaccompanied interactions. The findings of the influence of the companion's presence on patient's participation were generally that that patient's talked less when a companion was present (Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Robson et al., 2013; Wolff et al., 2011). In Robson et al. (2013) is particularly relevant because their research used the same data set as this thesis. They measured the amount of discourse space the participants took up by the number of words produced and found that patient's occupied significantly less discourse space when accompanied versus unaccompanied. This difference in the level of participation was mentioned as being potentially detrimental to providing an opportunity for patients to produce linguistic features (Robson et al., 2012) that can help neurologists with diagnosis.

While overall participation of patients was found to decrease when a companion was present there were some exceptions (Laidsaar-Powell et al., 2013; Shields et al., 2005). As discussed earlier under the subheading of patient's characteristics, the level of patient participation is influenced by certain patient characteristics, these same characteristics tend to also predict the likelihood that patients will be accompanied. This means that patient characteristics that influence which companions are accompanied also influence their level of participation and should be controlled when making claims about the influence of companions on patient participation. For example, in Shields et al. (2005) there was no difference in how many words patients spoke in accompanied and unaccompanied encounters, physicians were found to have longer uninterrupted turns of talk in accompanied consultations. Shields et al. theorised that their results were different from previous studies because patients were randomly assigned to be accompanied or not accompanied rather than using naturally occurring accompanied and unaccompanied groups based on whether the patient brought someone with them, and that some of the difference in participation found in other research may be related to patient preference for participation and therefore likelihood to bring a companion (Shields et al., 2005). This was supported by Laidsaar-Powell et al. (2013) in their systematic review, who also pointed out that patient's participation was also affected by their health (including mental health) and that patients whose health was worse were also more likely to be accompanied. Additionally, Wolff et al. (2016) found that companions were more verbally active in consultations when accompanying a patient who delegated the management over their health, compared to accompanying patients who co-managed or self-managed their health.

Research of participation measured by selected behaviours tends to overlap with other themes in this review, as they often centre around question-asking, information-giving, and decision-making behaviours, these tie into other themes around information exchange and concerns of patient-centeredness which is addressed in other parts of this review. However, while these behaviours are important themes on their own, they are also used as measures indicating a level of engagement in the consultation rather than just looking at the percentage of the total time the patient talks.

Street & Gorden's (2008) study looked specifically at companion participation by coding the verbal behaviour of patients and companions. They found most accompanied patients talked more and were more assertive than their companions; however, when companions did talk, more of their talk was coded actively participating (e.g. asking questions or expressing a concern, opinion or preference.). Street & Gorden (2008) also examined predictors of companion participation and found that companions participated more when there were facilitative behaviours from the physician, such as partnership building and supportive talk. They were also more active in consultations where there been a confirmed diagnosis prior to the visit. The study also found that companions were less active in consultations where patients reported better mental health.

There is also a difference in the nature of participation of adult patients versus child patients. Many papers observed that children tended to be less active in consultations, taking a more passive role than their adult counterparts. One study (Pyörälä, 2004) that compared two-party interactions with 3-party interactions found that children had a more active patient role in two-party interactions with a medical practitioner but became more withdrawn and in three-party interactions, and allowed their parent to speak for them.

6 Turn-taking

A small number of papers have examined how participation occurs in these interactions, focusing on the mechanisms of turn-taking, as described in conversation analytic research. These examine how the next speaker is selected in patient-companion-physician encounters. This is related to the area of participation but instead of looking at overall participation levels, is concerned more with how companions come to participate.

Tiitinen and Ruusuvuori's (2012) paper is one example of this kind of research. They were interested in speaker selection in triadic interactions in maternity clinics, where the expectant mother, expectant father and a health nurse were present. They found that the direction of health nurse's gaze at the end of her question determined who was the next

speaker. The relationship between gaze and next-speakership was found to be statistically significant. These results interacted with another contextual factor; the mother was orientated to as the principal respondent in these consultations, through the use of gaze that selected her as the next speaker. This was most strongly seen in questions verbally addressed to both parents, where the mother was typically treated as principle respondent by all participants, the nurse would treat the mother as the principal respondent through gaze, and the father treated treat her as the principle respondent by letting her answer. It was also found that in some cases when the turn was allocated to the father, the father did not respond but treated the mother as the principal respondent, and so the mother ended up being the first to answer. Their research showed how studying next speakership through gaze, reveals both the importance of gaze in determining who speaks next, as well as other unspoken aspects of speaker selection such as who is orientated to as the principal respondent. In their research, the mother was orientated to as the principle respondent and the father's participation was less active.

Gaze was also found to be important in Cahill & Papageoriou's (2007) study on primary care paediatric consultations, where parents were less likely to speak on behalf of the child when the child was addressed by name and they were in a position to see the physician's gaze was directed at the child.

Gaze and embodiment are not the only mechanisms of speaker-selection that studied in triadic consultations. How a question is designed specifically with the use of names, and pronouns play a role in selecting a next speaker. This is supported by Stivers's (2001) research on speaker selection in problem presentation and found child participation was the result of a combination of who selected to speak (through turn design) by the paediatrician, and a negotiation between parent and child over who would speak next. Doctors could design their turn to select the next speaker through using names, or pronouns and gaze; parents and children negotiated who answered by the parent prompting the child verbally or nonverbally (through gaze) to speak, and the child's gaze to the mother. One example in Stivers's research was a child not answering a question directed explicitly at them and then sharing a mutual gaze with the mother before the mother answered. Stivers's (2001) research shows how participation in triadic consultations is collaboratively constructed. Her findings were supported by Tates et al, (2002) who showed how parents and general practitioners enable or constrain child participation in consultations. They found that consultations often were initially addressed to the patients, but that if parents took responsibility for answering the questions and did not let the child answer for themselves, the GPs adjusted their questions

more towards parents. Both these studies showed how the level of participation of children in consultations was co-constructed between participants.

7 Communication dynamics

A common theme in the literature is how the companion influences the consultation. This theme is linked to many of the other themes discussed in this chapter such as information exchange, and patient participation and autonomy (M. L. Clayman et al., 2005), but is also focused on how companions influence patient satisfaction scores, doctor's rapport-building behaviours and the length of the consultation. Within these themes, the behaviours and influences of the companion are often classified as helpful or disruptive. Research on communication dynamics was examined through the following ways; research that examined companion's behaviours that are assessed as helpful or disruptive, research that compared accompanied consultations and unaccompanied consultations, and research that reported companion, patient and physician opinions of companion helpfulness.

7.1 Helpful and unhelpful behaviours.

Several researchers found companions facilitated doctor and patient communication (Cene et al., 2017; M. L. Clayman et al., 2005; Wolff et al., 2011, 2016). Wolff et al. (2016) examined the helpfulness of communication behaviours of family members of older adults in a primary care setting. They found that with more than half of the companion's behaviours directed to improve the doctor's understanding of the patient. Other studies found similar facilitation of patient understanding (Cene et al., 2017; M. L. Clayman et al., 2005), physician understanding (M. L. Clayman et al., 2005) and patient involvement. Disruptive behaviours were also explored but found to be less common overall in consultations (Laidsaar-Powell et al., 2013).

7.2 Influence of a companion

Research has also focused on how the presence of the companion can influence the consultation in general, including the physician and patient's behaviour, the topics discussed in the consultation and the overall duration of the consultation. While some studies have found a significant difference when comparing accompanied vs. unaccompanied consultations a systematic review, Laidsaar-Powell et al., (2013) found overall the impact of companions on consultations, in general, was not significant, and that such influences found were isolated to a few studies and not an overall trend. This was particularly the case in studies that compared

the duration of the consultation in accompanied vs unaccompanied visits. The influence of companions on the length of the visits was slightly varied, with some studies finding accompanied visits significantly longer (Wolff et al., 2011; Wolff & Roter, 2011), and some finding no significant difference (Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Robson et al., 2013; Street & Gordon, 2008).

Cene et al. (2017) found the presence of a companion increased physician's social rapport-building behaviours (e.g. chit chat) but decreased partnership building behaviours (e.g. checking patient understanding). They reported these findings could be seen as both positive or negative since there is some evidence patients tend to be more satisfied when more time in the consultation is spent chatting, however, more time spent chatting could mean less time covering patient's medical concerns. However, this influence was not found in other studies (Laidsaar-Powell et al., 2013).

As highlighted previously under the theme of Information-giving and receiving, companions have been found to influence the focus of information exchanged in consultations, with several studies finding physicians ask less psychosocial questions and provide less psychosocial information, but provide more biomedical information, and patients provide less psychosocial information (Cene et al., 2017; Wolff et al., 2011). Cene et al. (2017) described this influence of giving more biomedical information as positive, as it allowed physicians to enact a role they were more comfortable with and focus on the more 'technical" aspects of the consultation.

Whether a companion's presence influenced patient involvement was varied with several studies finding patients participated less when a companion was present and some finding no difference (Laidsaar-Powell et al., 2013). The number of words spoken by geriatric patients in Japanese primary care consultations was lower and their contribution to medical dialogue less when a companion was present (Ishikawa, Roter, Yamazaki, Takayama, et al., 2005). Older patients, in medical interviews, were found to have raised fewer topics when accompanied, and overall were less responsive and expressive in patient-raised topics and were less active in decision-making compared to unaccompanied patients (Greene et al. 1994 as sighted in Laidsaar-Powell et al. 2013), Alternatively Eggly et al. (2006) did not find a significant difference in the amount of questions patients asked in between accompanied and unaccompanied oncology consultation.

Street & Gorden et al. (2008) also found, in oncology consultations, that when comparing unaccompanied patients with the combined communication of companions and patients, there was not a significant difference, except for one finding - that unaccompanied

patients expressed more negative feelings than accompanied patients and their companions. They suggested that because the overall communicative profiles for unaccompanied patients compared to accompanied patients and their companions was not significantly different, companions may have balanced their participation, as when one participated more the other participated less (Street & Gordon, 2008).

Patient satisfaction ratings were a commonly measured outcome to test the influence of a companion's presence though their findings were inconsistent (Laidsaar-Powell et al., 2013). In their systematic review, Laidsaar-Powell et al. (2013) found an equal amount of studies (3) reporting no significant effect (Greene, Majerovitz, Adelman, & Rizzo, 1994; Labrecque et al., 1991; Shields et al., 2005) on satisfaction scores, compared to those studies that did (Rosland, Piette, Choi, & Heisler, 2011; Street & Gordon, 2008; Wolff & Roter, 2008).They also commented that what was measured as satisfaction differed across the studies, as what patients were rating satisfaction on differed (physician's skill, physician's care, satisfaction with the encounter etc.) and few studies looked at patient satisfaction and the interaction with companions in depth (Laidsaar-Powell et al., 2013). Of the studies Laidsaar-Powell et al. (2013) cited finding a significant effect of companion's presence and activity, the effect tended to be positive. For example, Wolff et al. (2008) found that after controlling for sociodemographic and health differences, patients who were accompanied reported significantly higher satisfaction levels with their physician's skills. For one study (Street & Gordon, 2008), patients' satisfaction scores tended to be high regardless whether they were accompanied or unaccompanied. They did, however, find a significant difference in satisfaction scores and the level of companion participation. Patients in consultations where companions were relatively equal in verbal activity (between 40%-60%) to patients, tended to have slightly lower satisfaction scores than patients whose companions either participated significantly less, or participated significantly more than them.

7.3 Patients' and physicians' assessments of companion helpfulness.

In a number of studies patients, doctors and/or companions were asked to rate their judgement on the helpfulness of companions in interactions (Laidsaar-Powell et al., 2013; Rosland et al., 2011; Schilling et al., 2002). Seventy-five percentof patients in Schilling et al (2002) reported believing that companions influenced medical encounters positively, mostly by facilitating communication between physicians and patients. Similarly, in Rosland's (2011) study patients reported that when companions participated in visits they (patients) were more likely to raise difficult topics with the physician (44%) and more likely to understand the physicians (77%).

In Schilling et al. (2002) doctors were also in agreement about the helpfulness of companions in facilitating patient (60%) and physician (46%) understanding. Companions were also reported in several studies to increase doctors' (Cene et al., 2017) and patients' (Wolff & Roter, 2008) self-reported ratings of satisfaction with the consultation. Providers in some studies reported that companions exhibited far more helpful behaviours in consultation than disruptive behaviours (Cene et al., 2017). Physicians in Rosland's (2011) survey were also positive about companion participation but did highlight some barriers to encouraging companion participation. These barriers included concerns about privacy for the patient, concerns that the presence of the companion increased the burden on physicians and that they were not adequately trained in communication techniques specifically for communicating with companions.

8 Autonomy and patient centeredness

One of the main concerns in triadic medical communication is that the presence of a companion might negatively impact patient-centeredness in consultations and that companions will dominate and their concerns detract from the patients, leaving the patient with less of a voice in their care. Measures used to measure patient-centeredness included measuring patient participation, something that has previously been discussed in section 5 of this chapter, as well as coding behaviours that are indicative of engagement like question asking.

Autonomy in medical consultations tends to be measured by considering behaviours around the decision-making process. A lot of the research on autonomy and patient-centeredness is focused on high dependency groups, specifically children, oncology patients and older patients (Laidsaar-Powell et al., 2013). However, even outside these specific groups, there is the concern that the presence of a companion may erode patient autonomy and the patient-centeredness of the consultation.

Research on companions in patient centred care is mixed. Several studies found that companions facilitated decision making and advocated patients concerns, acting as a support for patients rather than detracting from patients (Laidsaar-Powell et al., 2013). This was more often the case in adult-patient consultations. Both Clayman et al. (2005) and Ellingson (2002) identified that companion's behaviours were facilitative of patient decision making. Clayman et al's (2005) study focused on the behaviours of companions that were autonomy facilitating or autonomy detracting. They defined autonomy facilitating behaviours as facilitating patient understanding, facilitating doctor understanding, and facilitating patient involvement.

Behaviours that facilitated patient understanding included repeating what the doctor had said, and asking the doctor questions. Facilitating doctor understanding involved clarifying or expanding the history of the patient, and introducing medical topics. When they facilitated patient involvement, they prompted the patient to discuss a topic, asked the patient questions or asked the patient's opinions. These kinds of facilitating behaviours have also been found by Ellingson (2002).

The potential of companions to negatively influence autonomy was also discussed in these studies. Claymen et al. (2005) identified several autonomy distracting behaviours. These behaviours included being controlling towards the patient and alliance building. Actions that were coded as being controlling towards the patient were behaviours like answering instead of (i.e. in place of) the patient, interrupting the patient repeatedly, and discussing their own health instead of that of the patient. Alliance building was considered to consist of actions like trying to persuade the patient to do something the doctor wanted or to try and get the doctor to agree to something the companion wanted.

Claymen et al. (2005) found overall that companions tended to perform autonomy-facilitating behaviours more often than autonomy-detracting behavours. The largest proportion of companions performed at least one autonomy related behaviour and no autonomy detracting behaviour. They also found that companions did not perform autonomy detracting behaviours without also performing autonomy facilitating behaviours. Other research that examines both facilitative and detracting behaviour seem to be in consensus that while companions can both be facilitative and disruptive to patient-centeredness, the trend is that companions are more often facilitative (Ellingson, 2002; Laidsaar-Powell et al., 2013). Claymen et al. (2005) found a slight gender difference where female companions were more verbally dominant but engaged in more autonomy-enhancing behaviours such as asking questions, prompting the patient, and asking the patient's opinion.

There were some studies focusing on adult-patient consultations that did find companions could negatively influence patient autonomy. Wolff & Roter (2011b) found that patients who had poor mental health and were accompanied were less likely to experience patient-centred communication compared to companions who were unaccompanied (Wolff & Roter, 2011).

However, the dynamic in patient-companion-physician interaction with adults when it comes to autonomy and patient-centeredness is different from the dynamics of child-parent-physician interaction. It was found in several studies on paediatric consultations that child

patients played a more passive role in the interaction (Tates, Elbers, Meeuwesen, & Bensing, 2002; Tates & Meeuwesen, 2001; van Staa, 2011).

Buchbinder (2009) examined the transfer of responsibly from parents to adolescents in managing type 1 diabetes. In their research, they used conversation analysis to identify the interactional practices that both facilitated and inhibited the autonomy of a 13-year old patient. They found that while the medical practitioner facilitated the patient's contributions in identifying problems, the patient's autonomy was limited when it came to discussing problem solutions. Buchbinder (2009) observed that there was a tension in facilitating the adolescent's autonomy and solving their medical problems quickly, and that the medical practitioner often prioritised the latter. Their findings align with similar research on primary care paediatric consultations (Tates, Elbers, et al., 2002) reporting that, particularly during the last phases of the consultation (diagnosis and treatment information), the patient's voice is rarely heard (in 90% of the consultations the patient did not participate at the end of the consultation). Tates et al, (2002) highlighted that this non-participation by the child patient was not solely because the adults dominated, but was co-constructed by all three participants, a finding that was supported by other studies (P. Cahill & Papageorgiou, 2007b; Stivers, 2001).

Patient characteristics were found to influence patient's overall participation in decision making, as stated in the subsection of this review focusing on patient characteristics. There is also a difference in the research that looks at companions in adult medical consultations and paediatrics. Children are less active and seen as less competent than adults in medical interactions. Parent companions tend to also have more entitlement and responsibility when it comes to the decision-making process. Where there are elements of companion guardianship over the patient, and the patient is perceived or is less verbally competent, the companion tends to play a larger role in the interaction.

With the research provided in this review on adults with companions, this is more nuanced, possibly because the majority of research focuses on patients that are considered "cognitively competent" and so patients who are more dependent and considered less able to make decisions themselves are not fully represented in the research. However, Karnieli-Miller et al. (2012) touched on this in their study on triadic consultations in first-time diagnosis consultations with Alzheimer's patients; they report that triadic consultations are mostly alternating dyadic pairs, with a third participant attempting to become active with varying degrees of success. They discovered that within this consultation there was a shift in the core dyadic pair from doctor-patient to doctor-companion.This shift happens over the

duration of the consultation and reflected a change in patient-centeredness. As the consultation changes from the patient being talked to, to where the patient was being talked about and referred to third person pronouns. This change also marked a shift in the third person's role from companion to caregiver. When this kind of shift happens over the duration of a consultation the patient becomes less active. Karnieli-Miller et al. (2012) attributed some of this shift to confusion on the part of the patient, which leads doctors to turn to companions for confirmation. The helpfulness of companions in these clinics is perhaps largely in the eye of the beholder as they can arguably be disruptive and detract from the patient-centred nature of the consultation; but caregivers can provide information that they feel is important for the patient's care, especially in cases where the patient may be confused.

Wolff et al (2016) found that patients who preferred involving the family in decision-making rated companion's contributions as more helpful, and companions who accompanied patients who had a preference to delegated health care tended to be more verbally active. The relationship of the companion to the patient has also been found to make a difference in how involved a companion is in decision making. Clayman et al (2005), while looking at geriatric primary care visits found the family members such as a spouse, or children were more likely to engage in decision making than friends. Non-spousal companions were not as active in decision-making but more likely to facilitate patient involvement in visits than spouses.

9 Diagnostics

A small number of studies, mainly in neurology (memory and seizure clinics), have focused on the possibility that the presence of companions might be relevant in assisting diagnostics. These studies tend to focus on how the patient's behaviour, (and increased needs) may manifest in identifiable patterns in behaviour in interacting with companions that can be used for diagnosis.

The presence of the companion in dementia clinics has been proposed as a possible diagnostic tool (Elsey et al., 2015; Fukui et al., 2011; Jones et al., 2016; Larner, 2005, 2012). Whether the patient is accompanied, and how often they turn to look at their companion, to recruit help answering a question were both found to be indicative of cognitive impairments (Elsey et al., 2015; Fukui et al., 2011; Larner, 2012).This aligns with broader research on patient characteristics, and the likelihood of bringing a companion (Laidsaar-Powell et al., 2013), but is more focused on the proposed use of this relationship in an area where cognitive impairments are being diagnosed. Larner (2012) observed that very few unaccompanied patients exhibited evidence of cognitive impairments. They observed the patient's head-

turning behaviour towards the companion, usually to recruit help answering a question. This head-turning behaviour is called Head Turning Sign (HTS) in the literature. Larner (2012, 2005) and Fukui et al (2011) found that increased HTS is associated with cognitive impairments and Alzheimer's Disease. Fukui et al. (2011) examined HTS in relation to different dementia diseases and found significant differences. They found that HTS was significantly higher in the Alzheimer's disease-related group (this included Alzheimer's Disease and amnestic mild cognitive impairment) than in the non-Alzheimers related group (Vascular dementia, dementia with Lewy bodies and those with progressive supranuclear palsy). The cognitive ability scores between the two groups were comparable (Fukui et al., 2011).

Elsey et al (2015) and Jones et al. (2016) found that that patients with progressive neurodegenerative disorders leading to dementia (ND) were more likely to be accompanied compared to patients with functional memory deficits (FMD). Both papers also found interactional differences between ND and FMD patients. Elsey et al. (2015) focused more on triadic interactional differences, between ND and FMD patients, in their study when the neurologist asked, “who is more concerned about the memory problems” FMD patients were more likely to say themselves while in the case of ND patients the accompanying companion was more likely to say they were the most concerned. There were also interactional differences between companions of ND and FMD patients. Companions of ND patients tended to act more as spokespersons for the patient, while companions of FMD tended to act as a resource for the patient to check the accuracy of their response (Elsey et al., 2015). Jones et al. (2016) focused more on the dyadic features of the interaction (between the patient and doctor) but noted that patient’s difficulty answering questions accurately and use of working memory to answer compound questions, or recall information they had already given were indications of an ND diagnosis as opposed to an FMD diagnosis (Jones et al., 2016). Both these papers demonstrate the relationship between patient’s characteristics (being able to answer without difficulty) and the presence, and contribution of a companion.

The possibility of the presence of companions being diagnostically relevant has also been explored in seizure clinic consultations. In a study by Robson et al., (2016) the behaviour of companions was examined as a possible indicator of the difference between a diagnosis of epilepsy and non-epileptic seizures (PNES). The study found that companions’ behaviour was correlated with behaviour from patients that have been previously identified as being diagnostically relevant. Patients who have PNES are more resistant to answering questions about their attacks, and this led to companions providing a greater contribution to

the interaction. The study identified an interactional pattern in which companions describe patients' seizures, and drew a link between the common ways companions became involved with the level of resistance the patient had to the doctors questioning. However, the study questioned the usefulness of using companion's level of involvement and how they are involved as a diagnostic tool, as there are some concerns that the increased involvement of the companion detracts from opportunities to observe linguistic features from the patient that may help in diagnosis (Robson et al., 2016).

10 Method

Coding observed behaviours and questionnaires were the most commonly used methods in research investigating triadic communication in medical encounters. Some of the research that was solely based on questionnaires was not covered in this review as the focus was on the perception of the companion's influence on medical consultation rather than actual involvement. However several studies reported the results of observational methods and questionnaires (Cene et al., 2017; Fortinsky, 2001; Laidsaar-Powell et al., 2013; Wassmer et al., 2007; Wolff et al., 2011, 2016; Wolff, Boyd, Gitlin, Bruce, Roter, et al., 2012; Wolff, Boyd, Gitlin, Bruce, & Roter, 2012). Survey's in such studies were often used to compare variables such as satisfaction to the companion's presence, or behaviour (coded in a way to make it a statistical variable). They also used surveys to give a sense of what the perceived role of the companion within the consultation was and whether participants thought the presence of a companion was useful.

The kind of observational studies used varied. Different studies used different coding systems, depending on their research question, but often coded behaviour like question asking; for example, Clayman et al.(2005) counted behaviours, they defined as either autonomy facilitating or autonomy detracting. This kind of observational study often used audio or video data and transcripts to collect coded instances of behaviours.

Other observational methods, like conversational analysis also used video and audio data. The main difference between a study that used CA and a study that used coding systems of studies was the focus of the study. Studies that used a form of coding often used statistics to compare differences between accompanied and unaccompanied patients. They tended to try and answer questions about the general helpfulness of companions and used data that was more easily quantified; while studies that used conversation analysis tended to look at how certain practices were managed, or how companion came to be involved in the interaction within consultations.

Experimental designs were less common. Most research, except for one (Shields et al., 2005), used groups of accompanied and unaccompanied companions that were "naturally occurring". The one study (Shields et al., 2005) that had a more quasi-experimental design randomly assigned patients as to whether they would be accompanied or unaccompanied, rather than letting the patients choose by showing up with companions or not. Their study showed how using naturally occurring configurations of accompanied and unaccompanied patients may bias the observed differences between the two since the patients who need more help, or prefer a companion to play a more active role are more likely to bring a companion.

11 Summary

Overall the literature showed that research on companions has tended to focus on clinical contexts where there is a greater likelihood of being accompanied (paediatrics, maternity, dementia, geriatrics, oncology, palliative etc) due to the age (either young or elderly) and needs of the patient (i.e. chronic conditions). The review also revealed a growing body of literature in neurology, such as memory clinics and (as in the present research) seizure clinics.

Patient characteristics can predict whether a patient was accompanied, with patients with higher needs tending to be accompanied more often. This has also been identified as a confounding effect in companion research because, when comparing participation levels of accompanied and unaccompanied patients, researchers should take into account patients' communication needs and their possible preference to be more passive when accompanied.

Research on companions has tended to be concerned with themes of participation, turn-taking, their role, information-giving and receiving, their influence on diagnosis and the consultation as a whole, and patient-centredness and autonomy. These issues are, of course, interconnected, but different studies have placed different degrees of emphasis on them depending on the medical context studied.

Research in paediatrics has tended to focus on negotiating patient and companion participation, and on balancing the growing autonomy of the child patient with the parental rights of the parent companion. Autonomy was also of concern in geriatric and oncology research, but these studies also focused on the general helpfulness of companions, their roles in the consultation, their effect on information-giving and receiving, and other communication dynamics. This highlights how the presence, role and helpfulness of the companion are not taken for granted in adult-patient care in same way that they are in paediatric care. In neurology, meanwhile, the use of companions as a diagnostic tool has also been investigated. This is related to the finding that patients with higher needs, including higher communication

needs, tend to bring a companion, but also includes a focus on how differences in the way that companions contribute to the interaction can contribute to a diagnosis.

Research has found that companions fulfil several roles within consultations, including offering emotional support and informational support, as well as facilitating decision-making. On the aforementioned debate about whether companions are a disruptive or supportive presence, the research has tended to come down on the latter side, showing that, while some companions can indeed exhibit disruptive behaviours, they overall tend to facilitate understanding between patients and doctors. While it is true that research on participation often showed that the presence of a companion could decrease the amount of time the patient spent talking, this needs to be balanced by the finding (above) that patients who preferred being more passive were more likely to bring a companion. The research also showed that a companion's role in the talk tended to be interactionally negotiated by all participants.

This thesis fits into the wider research by looking the role of the companion in seizure clinics, using CA to look in depth at how some of these roles may be enacted within the consultation. Parallels can be made with some of the roles described by other studies that have observed and described the companion's roles in other contexts (Cordella, 2011; Ellingson, 2002; Laidsaar-Powell et al., 2013; Schilling et al., 2002; Street & Gordon, 2008), especially the companion's role in informational emotional support. However, instead of examining, for example, how companions provide informational support in general, this study focuses on specific patterns of informational support, and describes how they play out within the interaction.

This thesis, in line with CA research in other clinical contexts, analyses turn-taking to show how participants orient to the patient's right as principal respondent (P. Cahill & Papageorgiou, 2007b; Stivers, 2001; Tates & Meeuwesen, 2000; Tiitinen & Ruusuvuori, 2012). It also recontextualises concerns in the wider literature about the companion's presence impacting upon patient participation and patient-centeredness (Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Laidsaar-Powell et al., 2013; Robson et al., 2013; Shields et al., 2005; Tates & Meeuwesen, 2001), particularly in relation to seizure clinics (Robson, 2013).

The previous two chapters have thus established a clear framework for the study of companions in medical interaction. With this in place, we are now ready to move on to the analysis. The aim of this analysis is, to reiterate, to study companion participation in seizure clinic interactions. In some respects, it will build upon and complement the literature and

themes outlined above, looking at how companions can fulfil various roles relating to (amongst other things) information exchange, emotional support, and decision-making. In other respects, it will challenge existing findings and assumptions about the companion role and open up new avenues of research.

CHAPTER 3 COMPANION PARTICIPATION IN THE SEIZURE CLINIC

1 Introduction

This chapter examines the sequential context in which companions participate in seizure clinic interactions. A similar study by Robson, Drew and Reuber (2016) explored the companion's contributions in seizure clinics and the significance of these contributions for diagnostic purposes. There is some overlap between the findings of their study and this thesis, as they too explored some of the sequential contexts in which such contributions occurred. However, Robson et al. (2016) used 13 interactions and only focused on the history-taking phase. In comparison, my analysis is based on 30 interactions, and focuses on companion's contributions in *all* phases of the consultation. This is because the aim of this chapter is more broadly interested in the ways a companion comes to contribute to the discussion.

The categories used in the coding of this chapter were developed using previous conversation analytic research on speaker-selection (Lerner, 2002, 2003; Sacks, Schegloff, & Jefferson, 1974; Stivers, 2001; Stivers & Rossano, 2010; Tiitinen & Ruusuvuori, 2012) and the methods used to accomplish it. For instance, previous research has found that speakers use gaze to select the next speaker in every-day interaction (Holler & Kendrick, 2015; Lerner, 2003; Rossano, 2011; Stivers & Rossano, 2010). These findings also have also carried over into medical interactions. Stivers (2001), for example, highlighted the importance of gaze in paediatric interactions, showing how participation was co-constructed. These findings were supported by Cahill and Papageorgiou (2007). Tiitinen and Ruusuvouri (2012), meanwhile, found that gaze was used to engage fathers in maternity clinic interactions. Research has also shown that speaker selection is also influenced by question designs (e.g. the use of address terms (Sacks et al., 1974) like pronouns and names can indicate to whom the question is addressed, as well as who it is about) .

For this chapter, I analysed 30 consultations in which a companion was present. Overall, I found 2007 instances of the companion's interventions, which I then coded into the following categories.

1) *Explicit invitation:* Where the companion is invited to talk by being directly addressed or questioned by either the doctor or companion.

2) *Embodied invitation:* Where the companion is invited by non-verbal selection using gaze (Holler & Kendrick, 2015; Rossano, 2011; Stivers & Rossano, 2010), but was not verbally invited.
3) *Volunteering:* when the companion self-selects to speak

The following table shows the overall spread of coded contributions by the companion.

Table 3.1 Percentage of companion contributions where the companion is invited or contributes.

	Explicit Invitation	Embodied Invitation	Volunteer	Unclear[5]
Percentage	20.2% (n=406)	27.6% (n=553)	42.6% (n=854)	9.7% (n=194)

This table shows that about half (47.8%) the companion's contributions were invited, explicitly (with a verbal invitation) or through embodied action (gaze), by either the doctor or the patient. It also shows that a slightly smaller percentage were volunteered (42.6%) by the companion themselves. There is thus a gradient of ways in which companions come to participate in these interactions, from explicit invitations through being questioned by the patient or doctor, through to volunteering (self-selecting) to initiate new actions (Figure 3.1.)

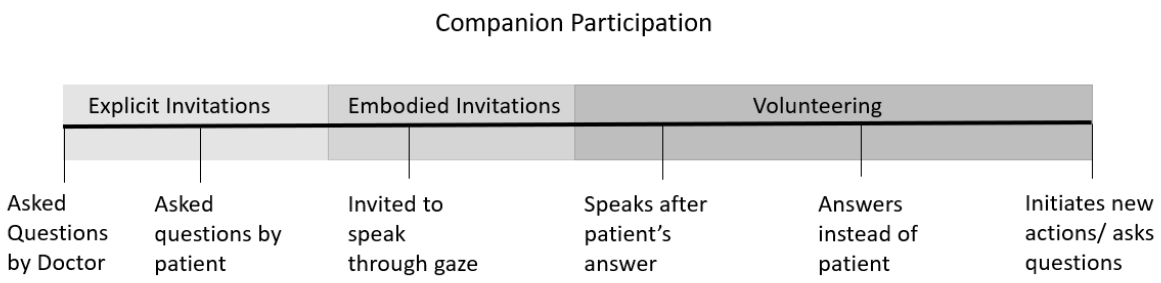

Figure 3.1 Gradient of ways in which companions come to participate.

[5] Unclear cases were cases where it was not possible to code distinctly into one category or another, usually because participants were out of frame, so gaze could not be seen.

This chapter looks at this gradient in detail, analysing both the sequential context in which companions are invited or volunteer to participate, and how an invitation or volunteering is recognisable as such. The analysis is divided into three sections. Section 2, firstly, focuses on explicit invitations and is organised into two subsections: instances when doctors initiate companion participation by explicitly inviting them, and instances when patients initiate companion participation by explicitly inviting them. Section 3 then focuses on embodied invitations, both from patients and doctors. Section 4, finally, focuses on instances where companions volunteer to contribute and is organised into three subsections. The first focuses on companions self-selecting after the patient's turn, the second on companions self-selecting to answer instead of patients, and the third on companions initiating talk, usually by asking a question.

2 Explicit invitations

Explicit invitations amounted to 20.2% of coded instances and occurred when the patient or doctor verbally selected the companion as the next speaker. There is a difference in the context in which the doctor explicitly invites the companion and in which the patient does so. As such, this section is divided into two sub-sections, the first focusing on doctor invitations, the second on patient invitations.

2.1 Doctor initiated participation.

This section focuses on instances where the doctor directly recruits the companion by asking them questions about the patient's seizures. This occurs largely (though not exclusively) within the history-taking phase, as a prolonged sequence where the doctor shifts focus away from questioning the patient, to questioning the companion. Note that patients are explicitly encouraged in a letter to bring someone who has seen a seizure with them, so these questions to the companion are an expected part of the visit.

In explicit invitations, doctors use both gaze and question design to direct their talk to the companion rather than the patient. These sequences commonly start after the patient has expressed difficulty remembering a seizure, and/or in moments where the companion has recently come in to contribute a related detail about the seizures. The following extract contains both of these features.

Extract 1 part 1 [162: Spouse: 2.00] (When she vomits…)[6]

```
31      Pat:  mm hmm
32            (0.8)
33      Doc:  and sometimes |you can remember °the vomit°,
                            |Figure 3.2 ((Doc looks at Pat))
34            (0.2)
35      Pat:  u:m (1.8) I would say I don't remember to be honest=
36      Doc:   =[mm hmm
37      Pat    =[I only know cos obviously (nom) there's a bucket there
38            when im (0.2) Awake
39            (5.6) ((Figure 3.3 doctor looking down and writing))
40--> Doc:    so ah (0.4) [w wu whe:n she vomits, d- does she vomit
41                        [ Figure 3.4((Doctor looks up at companion))
42            into the bucket? does she  aim at the b- bucket?
43            [or
44      Com:  [Ye]:ah she's (.) va:guely with it
45      Doc:  Mm [hmm,
46      Com:     [she kno:ws she's gonna be sick and will sit up and
47            (.) lea:n over the bucket
48      Doc:   Mm mm.
```

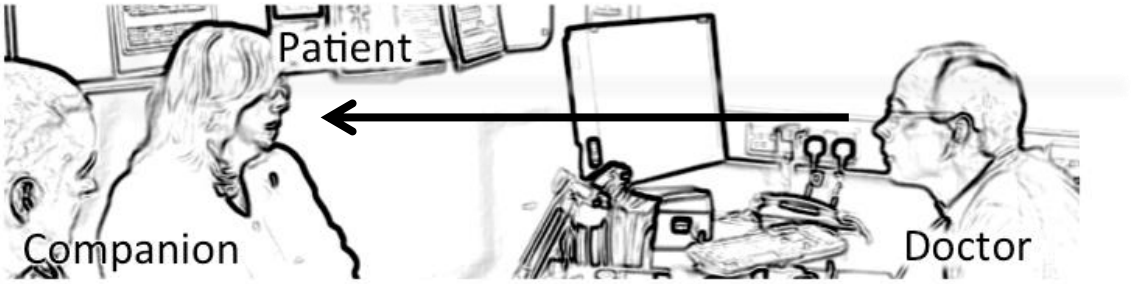

Figure 3.2 "Can you remember the vomit" (doctor looking at companion while directing a question at her)

Figure 3.3 Doctor writing in his notes, his gaze down

[6]Extract number part number [consultation ID number: companion relationship: time code] (title)

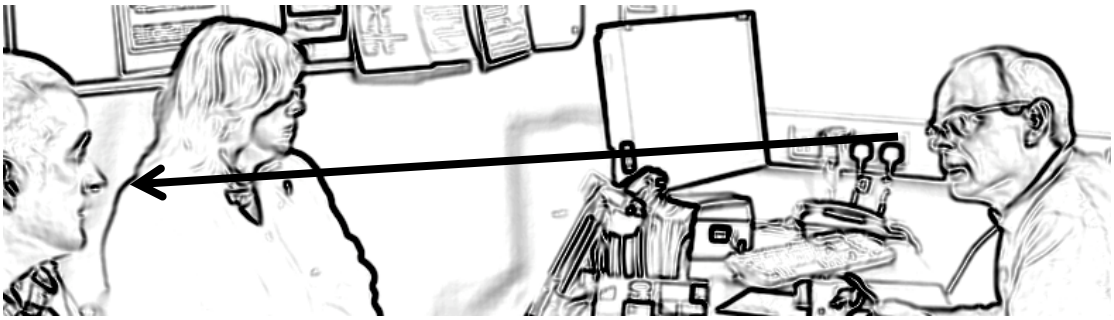

Figure 3.4 “So when she vomits” (Doctor’s gaze shifts to companion as he asks him a question)

The focus of this extract is line 40, where the doctor explicitly invited the companion to contribute. The doctor directed this question to the companion by shifting his gaze (Rossano, 2011, 2015) to him as he started to ask the question (line 40, Figure 3.4) and by using the third-person pronoun “she” to refer to the patient.

This invitation to talk did not come out of the blue. Looking at the sequential context, there are two features that precipitated it. The first is the difficulty the patient expressed in answering the question, and the second is that the companion was the one to introduce the subject of vomiting into the discussion. This can be seen in the extended version of Extract 1.

<u>Extract 1 Extended [162: Spouse: 2.00] (When she vomits…)</u>

```
01    Doc:  So these- (.) when when when was your last seizure?
02          (1.2)
03    Com:  Su:n:day
04    Pat:  Sunday
05          (0.2)
05    Doc:  Hmmm.
06          (3.6)
07    Doc:  What can you tell me about that,
08          (0.8)
09    Pat:  U:m I don’t really remember a lot about them.
10    Doc:  Mm hmm
11    Pat:   U:m (4.0) kind of very very tired afterwards=don’t really
12          remember the event befo:re (1.4) leading up to it.
13    Doc:  Mmm
14    Pat:  Ahm  (2.4) obviously while I’m having a seizure I never
15          remember what happens during a seizure, (1.6) and then
16          normally I need to just sleep.
17          (5.4)
18    Com:  Quite often a lot of vomit well some
19          vo[miting afterwards as w]ell=
20    Pat:    [ye:ah vomiting        ]=
21    Pat:   =quite bad heada:ches.
22          (4.0)
23    Doc:   And when is the vomiting, immediately afterwards?
24          ((Doctor’s qaze is on his notes))
```

```
25          (1.8)
26    Com:  Pretty much yeah (0.4) once you've stopped sort of the
27          fittings and convu:lsions she (  ) come rou:nd slightly,
28          (0.4)
29    Doc:  So sometimes you can vomit, before you've (.) regai:ned
30          awareness.
31    Pat:  mm hmm
32          (0.8)
33    Doc:  and sometimes |you can remember °the vomit°,
                          |Figure 3.2((Doc looks at Pat))
34          (0.2)
35    Pat:  u:m (1.8) i would say i don't remember to be honest=
36    Doc:   =[mm hmm
37    Pat    =[I only know cos obviously (nom) there's a bucket there
38          when im (0.2) Awake
39          (5.6) ((Figure 3.3 doctor looking down and writing))
40 -->Doc:  so ah (0.4) [w wu whe:n she vomits, d- does she vomit
41                      [ Figure 3.4((Doctor looks up at companion))
42          into the bucket? does she  aim at the b- bucket?
43          [or
44    Com:  [Ye]:ah she's (.) va:guely with it
45    Doc:  Mm [hmm,
46    Com:     [she kno:ws she's gonna be sick and will sit up and
47          (.) lea:n over the bucket
48    Doc:   Mm mm.
```

The patient's display of difficulty started at lines 11-16, where she said that she didn't remember the details of her seizure. Difficulty remembering is a symptom of the patient's condition, of course, but it also functions here as an account for why she cannot give more information about what happened.

Although either the doctor or the patient could have come in during the silence after this account (line 17), neither did. This once again suggests difficulty on the patient's part. The silence extended for 5.4 seconds before the companion came in at lines 18-19 to volunteer (see section 4) another of the patient's symptoms: vomiting. The patient confirmed the companion's account by repeating it at line 20 ("yeah vomiting"). The doctor then solicited further information about the patient's vomiting at lines 23-24. The patient did not respond here, however, resulting in a 1.8 second silence. The companion thus came in once again, at lines 26-27, to talk more about the patient's vomiting.

All of these features indicate that the companion is knowledgeable about the symptoms that happen during and immediately after the seizures, while the patient has difficulty remembering them. However, before the doctor questioned the companion further about the vomiting, he directed more questions to the patient herself, using the pronoun "you" to do so (lines 29-30 and 33). While the patient did answer the first of these questions directly at line 31 ("mm-hm"), she was less certain about the second. She claimed that she didn't remember and that the knowledge she did have was based on evidence that was there when

she woke up (the bucket) (lines 35-38). It was only at this point, when it was quite clear that the patient was unable to answer, that the doctor invited the companion to describe the vomiting (line 40). The doctor directs the questions first to the patient, showing an orientation to the patient as primary respondent (Tiitinen & Ruusuvuori, 2012).

Extract 1 is an example of how sequential context plays a role in determining when the doctor starts to direct questions towards the companion instead of the patient. Although the doctor did ultimately end up asking the companion directly about the patient's symptoms, it was only after the patient made it clear that she was unable to do so herself. This suggests that there is an underlying preference for the patient to be the primary respondent, which can also be observed in how the patient was called on to confirm the companion's contributions. In other words, the context modified the preference.

A similar example can be seen in Extract 2.

Extract 2 [169: Spouse: 10.51] (So what happened)

```
01     Doc:  Any other health problems?
02     Pat:  I had a (sto- ) stroke la:st (.) March.
03     Doc:  So (what's) that?
04     Pat:  Sorry?
05     Doc:  What what happened the:re?
06           (0.6)
07     Pat:  U::m (0.6) >I can't remember<=I °just° I got home
08           and just didn't fee:l >well<=did I?
09           (0.4)
10     Pat:  Got home from work and just didn't feel right.
11           (2.9)
12     Com:  You pulled up in the car=didn't y[ou?]=
13     Pat:                                   [Mm.]
14     Com:  =>You< Didn't get out of the ca:r .hh so I went out to
15           see why you'd not got out the ca:r (.) and you said "I
16           don't fee:l ri:ght."=And then that was it=he was gone.
17           He w- you couldn't talk to him you couldn't (0.4) mo:ve
18           him (.) he just weren't the:re .hh So we called an
19           ambulance straightawa:y. (0.6) But (0.5) they
20           never fully diagno:sed it.
21           (0.5)
22--> Doc:   So what ha↑ppened? so he couldn't speak? He was just
23           F[lop]py: >or what<,
24     Pat:   [Mm.]
25     Com:  °Yeah° (0.5) He was floppy and unresponsive:: .hh even
26            when you tri:ed ta (0.2) prompt him to ta:lk and tri:ed
27            to get >his attention he< he weren't responding at a:ll.
28            (0.7)
29     Com:   U:m (0.2) I phoned the paramedics=they came ou:t (0.5)
30            and took him to hospita:l_ .hh U:m they said it was a
31            suspected stro:ke but they had- >didn't< fi:nd any
32            medical (0.5) proof=one way or the other.
33            (2.9)
```

Extract 2 is similar in structure to extract 1. Like that extract, the doctor asked the patient first about his own stroke (line 05), and the patient tried to answer. It was only after the patient displayed difficulty answering (by claiming not to remember and leaving silences) that the companion came in at line 12, and then only to offer a prompt ("You pulled up in the car didn't you"). When the patient did not take up this prompt, the companion answered on his behalf at lines 14-20.

It was at this point, when the preceding sequential context had made it clear that the patient struggled to remember and the companion did not, that the doctor asked the companion directly at line 22-23 (it is also notable that the patient solicited the companion's help at line 08 via the tag question "did I"). That this turn was directed at the companion is indicated both by the turn initial "so" (line 22) which links the turn to the companion's account and the use of the third-person pronoun "he." Like in the previous extract, the sequential context here modified the preference for the patient to be the primary respondent.

Extract 3 is somewhat different from the previous two extracts. In this case, the doctor's question (line 11) does not follow the patient saying that they don't remember. Rather, it comes after the companion has already taken the floor for another question. The companion having already spoken thus creates a sequential context in which the doctor can smoothly transition to questioning him.

Extract 3 [167: Spouse: 6.56] (So um what did you see?)

```
01    Doc:    =(    ) do you bite your tongue in these
02            attacks at all?=or your mouth,
03            (0.4)
04    Com:    .hh She's never (0.2) bit her tongue.
05            (0.2)
06    Com:    She's not had a- >you know< she's always uh
07            (0.4) had her tongue out °the° way.
08    Doc:    Mmm:.
09            (0.3)
10    Com:    It's ri:ght good that.
11    Doc:   S:o u:m what do |you see: in these attacks,
      Doc:                   |Figure 3.5
12            (0.7)
13    (?):   (((lipsmack))/tch)
14             (0.2)
15    Com:    U[::m.]
16    Pat:     [(U:mm)] Befo:re we were togethe:r .hh ah
17            >you know (even)< (0.3) betwee:n my >first
18            husband< dy:ing >and us< (meet-) .hh u:m I
19            had bit (0.5) e:r the insi[de of] me mouth.
20    Doc:                            [hmm. ]
21            (0.9)
22    Pat:    But I think that's the only ti:me I've ever
23            done #it.
```

```
24              (0.9)
25    Doc:    °Mm.°
26              (2.5)
27-->Doc:    °okay° s:o u:m what do you see,
28              (0.9)
29    Com:    E:r when er when she's ah- (.) going into a-
30              a seizure (0.2) you can (0.2) sometimes you
31              can tell.
32              (0.1)
33    Doc:    Mm[m.]
34    Com:      [th]at she doesn't seem to know. Heh heh
35              heh a: and, e[rm_
```

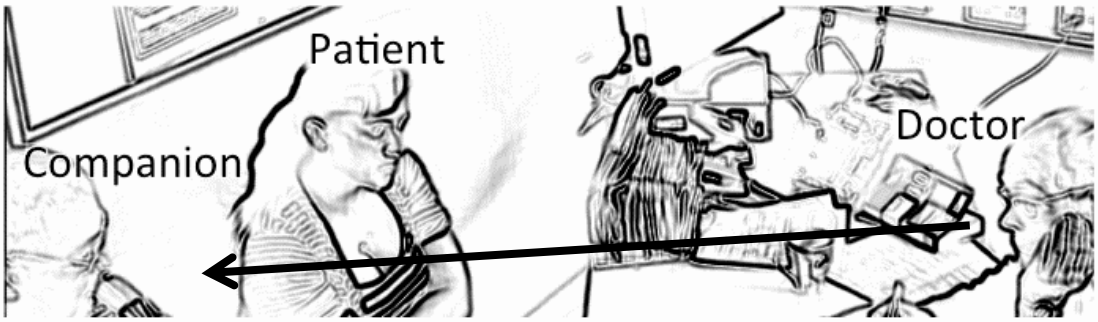

Figure 3.5 Line 11 "what do you see: in these attacks,"

There are two target lines in this example, line 11 and line 27. Line 11 is a clear example of the doctor explicitly questioning the companion, indicated by the way that he shifted his gaze to him as he says "you." The companion did not answer the question right away and, when he did begin to speak at line 15, the patient stepped in to correct the answer that he gave at lines 04-07. She claimed that the companion's statement that she "never bit her tongue" is incorrect because, epistemically, the companion could not have known about the incident when she did bite her tongue before they met (lines 16-17).

After this, the doctor repeated the question to the companion at line 27, and the companion answered at lines 29-35. Note, again, that this question is to be expected, given that patients are advised to bring along someone who has witnessed a seizure to the consultation.

Extract 4 is another example of the companion being asked what they witnessed when the patient had a seizure. Unlike the previous example, it is not latched onto the previous questions with a turn-initial "so". However, the question design indicates a shift in questioning.

Extract 4 [166: Spouse: 3.16] (Do you notice anything?)

```
01    Pat:  E::::r, (1.7) (mcht) (0.8) I notice that (2.4) I might
02          (0.2)s- set off to ↓do someth:'↓ wu w- w- (1.0) well
```

```
03          (1.2) ( we're going) fi:rst (0.7) and then (1.0) °°a:h°°
04          probably: few seconds later, (oh yeah). Right. ((   ))
05          yeah, (0.8) °so: ° (0.3) It's just littl:e lapses °and
06          er° (0.9)((    )) (there'll be) a big lapse.
07          (0.6)
08    Pat:   °so:, °
09          (0.6)
10    Doc:  Okay so:, (1.4) Are you ever unco:nscious? (0.4) with
11          this.=You're not it's no[t,
      Doc:  ((Figure 3.6))
12    Pat                            [No.]
13    Doc:  Okay. (0.9) Do |you notice anything?
      Doc:                 |Figure 3.7
14          (0.6)
15    Com:  Well I alwa:ys ((   about)  when (ah) when he's havi:ng
16          (0.6) one he a:lways |sits,>and I can always tell cos he
      Doc:                       |Figure 3.8
17          starts to< brea:the .hh (heavy like >and yah <) .hhhh
18          fwhhHHHH °he° like puff[s   ]and I go=
19    Doc:                         [mhm.]
20    Com:  = ">what's the matter.<" He says "I I'll be all right in a
21          minute, just lea:ve me a minute," (0.6) But he goes (0.3)
22          bright red,
```

Figure 3.6 Line 11: "You're not it's not,"

Figure 3.7 Line 13 "Do you notice anything?"

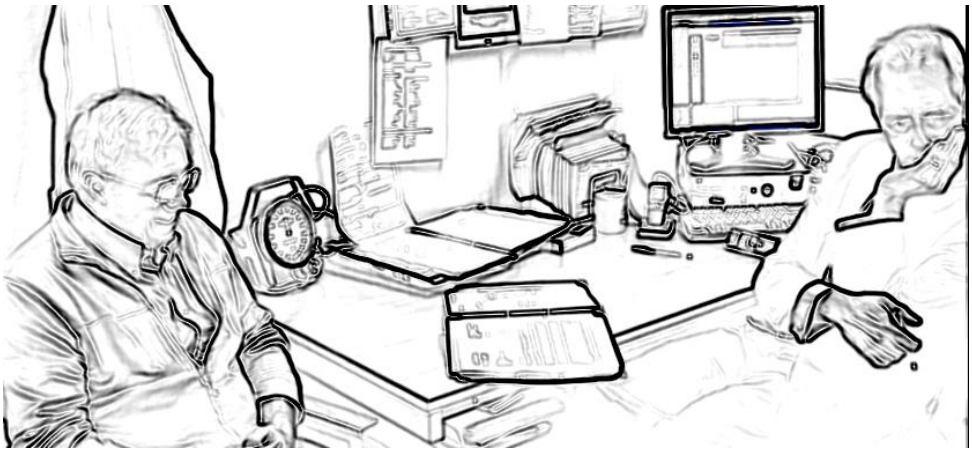

Figure 3.8 Line 16 “one he always sits, and I can always tell.”

The doctor turned to the companion at line 13, asking if she noticed anything. As in previous examples, the doctor made it clear that the question was directed at the companion by simultaneously using both question design (namely, the pronoun “you”, which is emphasised) and a shift in gaze (line 13, Figure 3.7). Unlike the previous examples, though, this question was not designed with a turn-initial *so.* Instead, the doctor has closed the previous questioning sequence with “okay” (Sacks, 1972) before starting this question.

These cases show that, while companions are expected to contribute in these consultations, sequential context plays a role in determining *when* they are asked to do so. Sequential features facilitating a companion contribution include patients displaying difficulty in being able to answer for themselves (extracts 1 and 2), the companion contributing to another question, thus creating a sequential environment for the doctor to ask them directly (extract 3) and the doctor starting a new line of questioning, directing the questions at the companion (extract 4).

2.2 Patient initiated participation.

Patient’s explicit invitations had slightly different features, and came in different sequential locations, to doctor invitations. This was to be expected, as the role of a patient in doctor-patient interaction tends to be more the answerer than the questioner.

Explicit invitations from the patient can come in the form of a tag question or a full question. Tag questions tended to receive confirmations, and full questions tended to receive longer answers that confirmed or collaborated with the patient’s account. Extracts 5-8 are examples of the patient recruiting the companion using a tag question and extracts 9-10 are

examples of the patient recruiting the companion using a longer question design. Like doctors, patients used gaze as a mechanism for selecting the companion.

Extract 5 [178: Spouse: 14.50- 16.03] (I'm not really stressed am I?)

```
01   Doc:   =.hh I wonder what (0.3) a- you know (0.3) whether
02          stress has |a_
     Com:              |Figure 3.9
03          (1.0) ((turning to companion))
04   Pat:   [We:ll| I'm,] I'm not really stressed am I:?
     Pat:         |Figure 3.10
05   Doc:   [(        )]
06   Com:   I don't kno:w=I think you- I think you are stressed
07          I thi[nk you ]
08   Pat:        [ With   ]Work li:ke.
09   Com:   Yea:h I think
10          (0.5)
11   Doc:   And what about a:l[l that's happened to you ]recently?
12   Pat:                     [We: ll   the   (struth ) ]
13   Pat:   the stress it's a worry (1.0) whe:n e:r (2.4) I'm off
14          Work=in't it?
```

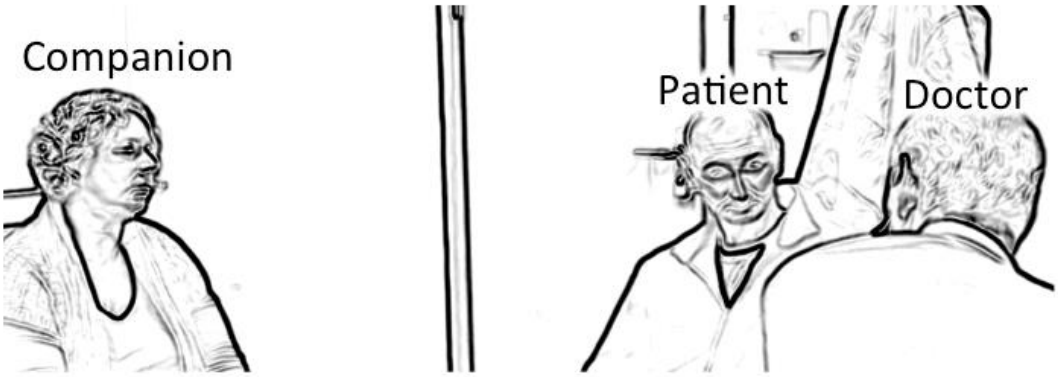

Figure 3.9 Line 02 "whether stress has a"

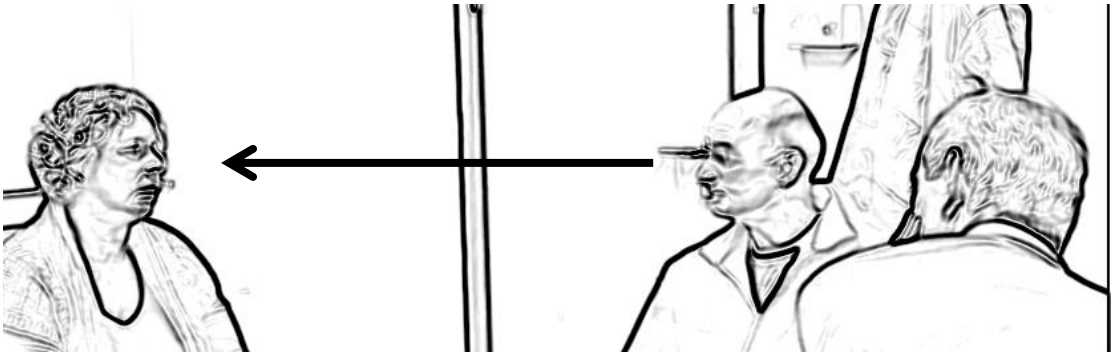

Figure 3.10 Line 04 "Well I'm, I'm not really stressed am I?"

The companion's contribution in extract 5 can be seen at line 06. This contribution was solicited by the patient's turn at line 4, which he ended with a tag question ("am I")

accompanied by a shift in gaze to the companion (Figure 3.10). With this turn, the patient was disagreeing with the doctor's suggestion that he might be stressed. Evidence of his disagreement can be seen in his use of "well" (Heritage, 2015) and "not really", both of which mitigated it. By soliciting the companion's contribution, then, the patient was seeking her confirmation of his disagreement. Such confirmation was not forthcoming, however, with the companion stating instead that she *did* think the patient was stressed. She did also recognise, however, that the patient's stress levels were not in her knowledge domain by downgrading the strength of her claim with epistemic markers like "I don't know" and "I think" (Heritage, 2012). Though the "I don't know" also indicates disagreement.

Example 5 is a deviant example in the sense that it is more normative for the companion to simply confirm when recruited through a tag question. The reason for the lengthier reply is because the companion was not confirming and had to account for her disagreement. By contrast, extracts 6 – 8 are more typical examples of the patient using tag questions to recruit the companion to confirm their account.

Extract 6 [161: Friend: 3.40] (Weren't they?)

```
01    Doc:  So two=three year history:, (1.5) What what do you u::m
02          remember of the attacks?
03    Pat:  Well when they fi:rst started they weren't that
04          ofte:n .hh an: i- it's always been same=my mouth goes to
05          one si:de I can't talk=I slur me words .hh an: me fist
06          clenches like that an: it just won't open till it's (.)
07          ready. .hhh And then er (0.5) they
08           |were only happening every so often |>weren't  they?<
      Pat:   |((start turning to com))           |Figure 3.11
09    Com:  [ y e  :   a  h]
10    Pat:  [They weren't h]appening all the time, then as time's
11          got on, they've got worse. They're happening like every
12          other, every day.
```

Figure 3.11 Line 08 "they were only happening every so often weren't they"

Extract 7 [170: Spouse: 28.52] (Don't I?)

```
01    Doc:  Ye:ah and (ev-) >you know< those=those situations are the
02          most difficult to deal with.
03    Pat:  [Yeah.]
04    Doc:  [(  ) ]there isn't e:r an >you know< actually a
05          c[on]clusion.
06    Pat:   [a-]
07    Pat:  That's ri:ght=there's no conclusion to tha:t.=Never
08          ((  [         ))]. (    talking together)
09    Doc:      [But (like y]ou sa:y) you ca:n't just turn stress off
10          >in your life< you have to: >you know< get on with
11          li[fe, um.
12    Pat:    [I do:,=that's>> what I do every da:y<<.
13           >|I just get on with< it |don't I:?=I don't-_
      Pat:    |(( turning to com))    |Figure 3.12
14    Com:  =Well tr:y [yeah.
```

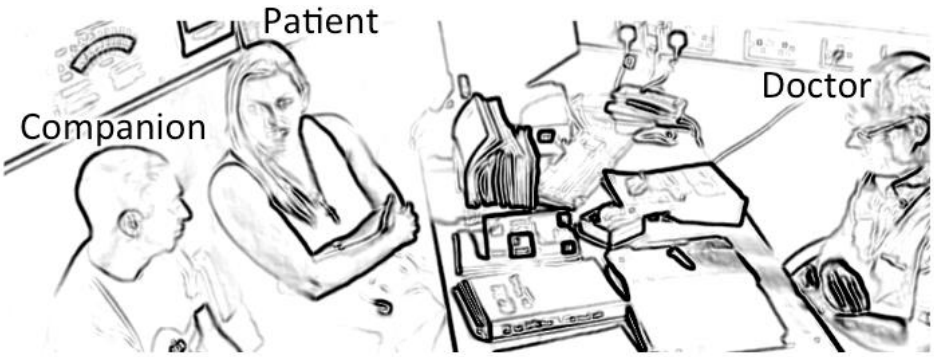

Figure 3.12 Patient turning to Com. (line 13)

Extract 8 [156: Parent: 1.36] (Weren't it?)

```
01    Doc:  How many: incidents have you had?
02    Pat:  I've only had two: now.
03    Doc:  Two?
04    Pat:  Ye[ah.]
05    Doc:    [Oka]:y=When was the first one.
07          (0.8)
08    Pat:  wa-, |Was it >now just< after  s[umme]:r, September=
                 |((turns to Com Figure 3.13[))
09    Com:                                   [( )]
10    Pat:  =weren'[t   i]t? |Yea::h,
11    Com:         [Yeah.]   |
                             |((turns to doc))Figure 3.14
```

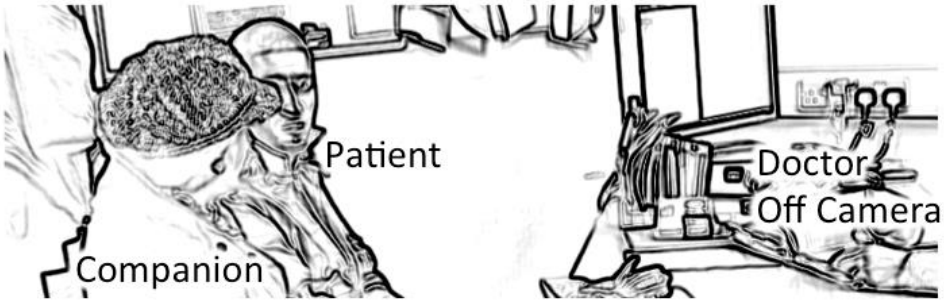

Figure 3.13 Line 08 “was it now just after summer”

Figure 3.14 end of extract

Tag questions tended to elicit minimal confirmations from the companions (Extract 6, line 09, Extract 7 line 14 and Extract 8, line 11). The confirmation in Extract 7 was slightly pushing back, with the “well try” inserting a “try” in before confirming “getting on with it.” The turn was still short, however, and did not interfere with the progressivity of the doctor-patient questioning.

The patient’s gaze was used to select the companion in each example. In Extracts 7 and 8 the patient’s gaze shifted towards the companion near the beginning of the statement that the tag question is attached to (Figure 3.12 and Figure 3.13), and in Extract 6 (Figure 3.11) the patient shifts her gaze as she asks the tag question.

Extract 9 is an example of a patient using a longer question to invite the companion. Longer questions tended to elicit correspondingly longer answers from the companion and occurred more often in situations where the companion was having difficulty answering. This can be seen in the extract.

<u>Extract 9: [162: Spouse: 3.38] (Was I watching TV?)</u>

```
01    Doc:  so the one on on sunday can you remember what you were
02          d↑oing at the time.
03          |(4.6) ((Pat turn’s her head slowly to Com))|
      Pat:  |Figure 3.15                                |Figure 3.16
```

```
04    Pat:  (   )I do Sunday?) (3.4) i must have been in the
05          living room but (0.4) was I watching |TV?
                                                 |Figure 3.17
06    Com:  maybe: you just sat on the sofa?
07          |(2.0)
            |Figure 3.18
08    Doc:  Mm. ((starts writing))
09         (2.4)
10    Com:  went very quiet and then started t- fitting and
11          convulsions. (4.8) cos they havent Alwa:ys had the sort
12          of fitting and convulsions element (1.8) thats
13          only happened=stuff happening in the la:st ↓wha:t six
14          seven mo:nths: i th[ink]
15    Doc:                     [mm ]mm
```

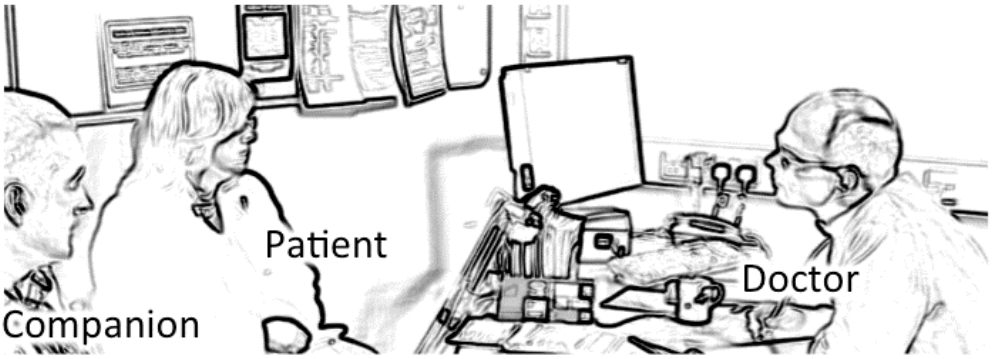

Figure 3.15 beginning of silence

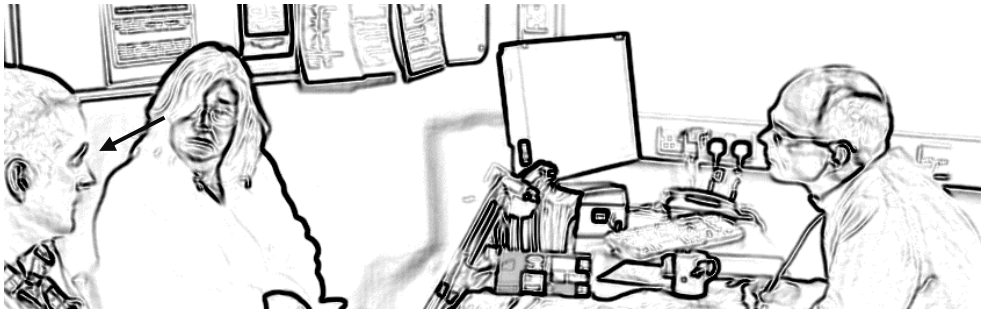

Figure 3.16 end of silence

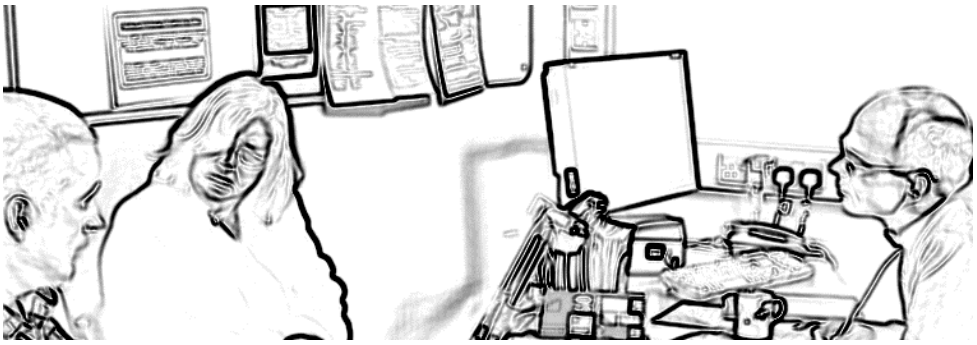

Figure 3.17 line 5 “was I watching tv”

Figure 3.18 after companion responds (line 07).

In extract 9, the target line is line 06, where the patient recruited the companion to help give a narrative of her seizure. She displayed difficulty giving this account (line 04-05), evidenced by the 3.4 silence before her turn and her use of "must", which marked her account as an inference rather than something she claimed to know for certain. During the 3.4 silence, the companion slowly turned her head towards the patient (Figure 3.15 and Figure 3.16), so that her gaze was on the companion as she said her account on lines 04-05. After another pause (0.4 seconds) she asked "was I watching TV", seeking a confirmation from her companion, her gaze still on him (Figure 3.17).

Just as the patient's question was longer than the questions in extract 6-8, so too was the companion's response at line 06 longer than the minimal responses seen in those extracts. It did not quite confirm the proposed account but added information about where she was. The patient's head turns back to the doctor after the companion responds (Figure 3.17). In contrast to the examples of patients using tag questions to invite, the patient did not pick up her account afterwards. Instead, after the silence, the companion took over giving the account of what happened.

Another example of a more substantial patient invitation soliciting a more substantial companion contribution can be seen in extract 10. In this extract, the patient turns to the companion while he is answering and suggests that she had said something of relevance previously.

Extract 10 [091: Spouse: 5.38] (Well I think you said...)

```
01    Doc:  Did you feel Oka:y or di- >were you< feeling achy or
02          with a headache [or?]
03    Pat:                  [  N]o: absolutely no: heada:che no
04          chest pai::n no:: neurologica:l symptoms or anything at
05          a:ll.
06          (0.8)
```

```
07    Pat:  U:::m I felt one hundred percent all right.
08          [( °hundred percent °)]
09    Doc:  [No pain i]n your li:mbs either, hadn't hurt yourself.
10    Pat:  No: I had brui:sed and gra:zed my fac[e u]:::m, |but=
11    Doc:                                        [mhm]      |
                                                             |Figure 3.19
12    Pat:  =I had no::_ |>well I think you said I
                         |Figure 3.20
13          [(had (   ))
14    Com:  [Well you aggravated a shoulder complaint=
15          di[dn't  ]you,[with] fa:lling.
16    Pat:    [°right]    [Yeah]
```

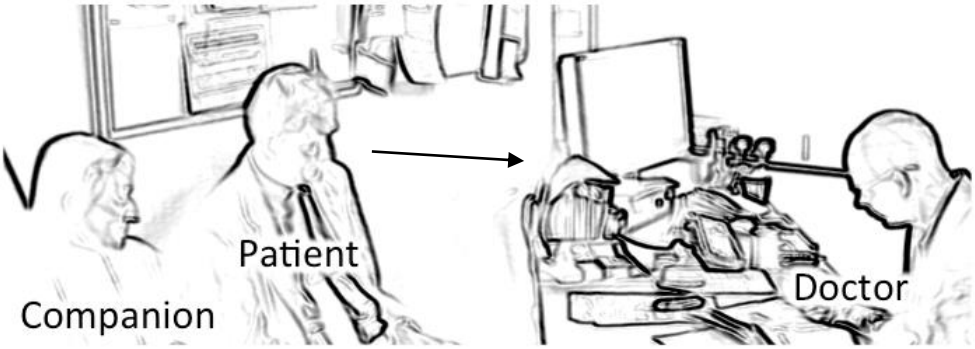

Figure 3.19 Lines 10-12 " but I had no::"

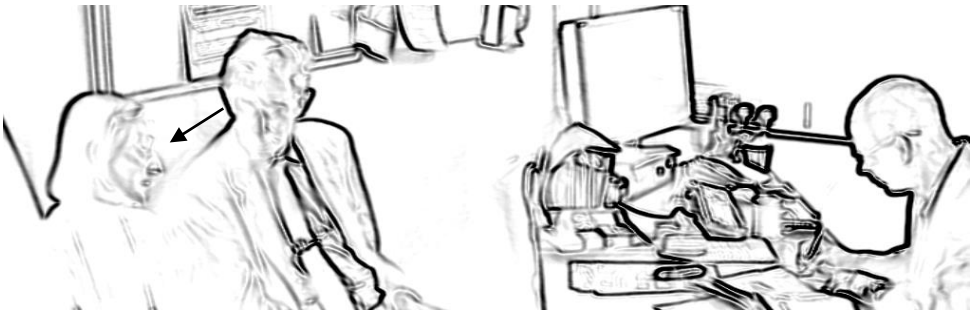

Figure 3.20 Line 12 "well I think you said"

In this extract the patient did not recruit the companion through a question. Rather, the companion was addressed by the patient while the patient referenced something the companion may have said in the past. The patient answered that he had not hurt himself in a seizure (line 10 and 12). However, at line 12 the patient self-corrected, stopping mid-sentence ("I had no::") to shift his gaze and address the companion: "well I think you said I had…". On "well" at line 12, the patient turned his gaze to the companion (Figure 3.20) and addressed the companion with "you". This was treated by the companion as an invitation to add to the patient's account by, presumably, repeating what the patient had alluded to them saying previously.

In this section, we have seen cases of the patient recruiting the companion, both verbally and through their gaze. Verbal recruitment included tag questions or fuller questions, with the former seeking minimal answers at points where the patient displayed less difficulty answering, and the latter recruiting the companion to help when the patient was having greater difficulty answering. Directed speech using "you" and looking at the companion, even if not grammatically a question, was also orientated to by the companion as an invitation to speak.

3 Embodied invitations by either the doctor or patient through gaze.

In 27.6% of the instances when companions came to talk, they were invited to do so without any explicit (spoken) invitations. One of the main features of embodiedinvitation is the use of gaze to recruit the next speaker. While we have already seen patients using gaze *in conjunction* with speech to recruit companions, with embodied invitations, gaze functions on its *own* to perform this function. Previous research has established that gaze is a mechanism for the management of turn-taking (Holler & Kendrick, 2015; Rossano, 2015; Stivers & Rossano, 2010). This mechanism is particularly obvious with embodiedinvitations, given the lack of a corresponding verbal invitation.

Most embodied invitations in the data come from the patient. There are, though, examples of doctors using gaze to recruit companion participation, one of which can be seen in extract 11.

Extract 11 [166: Spouse: 8.00] (Well I always said)

```
Doc:  Anything else that you notice or that [you notice,
Doc:      ((Gaze to Patient))               [((Gaze to Com))
Com:  i- It's just mainly his memory >as I say< his memory
      afterwards as well.
      (0.3)
Doc:  So his memory:'s- the- the memory disturbance
      a:fterwards:, As oppo:sed to mo:re qu- >you know< during
      the in- intervene[ing ((   ))? ]
Com:                   [   W E l l   ] I think every time he's
      had a- a- one of these episodes=his memory gets a little
      bit worse,=[don't it?]
Doc:             [   But   ] Okay  Y[e a h.( ahh ah-)]
Com:                                [That's what I me]an,
      and then it jus[t carri]es o:n. .hh But then it's- =
Doc:                 [ Yeah  ]
Com:  =it's ju:st little thi:ngs i- Daft thi:ngs.
Doc:  And you're slightly confu:sed afterwa:rds (0.6) After the
      attack.
Pat:  Sometimes yeah.
Doc:  °Slightly confu:sed°. Ho:w long do you take before you
```

```
21          get back.|
                     |Figure 3.21((Doc looks at Com))
22          (1.3)|
                 |Figure 3.22((Doc turns gaze to notes))
23    Pat:  ((Sniffs))
24          (0.4)
25    Com:  Well I always said before he gets (0.6) to how he wa:s
26          I:'d give him two or three da:ys. To get back to
27          no:rmal .hh but once he's got over that flush thing
28          hisse:lf,=
29    Doc:  =Yeah< and that lasts how long?
```

Figure 3.21 Doctor looks at companion

Figure 3.22 Doctor turns to notes

Whilst the companion contributed several times in extract 11, the focus here is her contribution starting at line 25. This turn was invited by the doctor, who, despite addressing his turn at line 20 to the patient himself ("How long do you take before *you* get back"), shifted his gaze to the companion at the end of it (as can be seen in Figure 3.21). Like in example 11,

the companion prefaced her turn with “Well”, indicating a longer answer was forthcoming (Heritage, 2015).

As noted above, embodied invitations in the data are more commonly given by patients. This extract, as a notable exception, provides some evidence to why this might be the case. One of the key jobs that doctors must perform in these encounters is to ask questions. In their design, these questions often explicitly and verbally select a next speaker. To invite a companion only through gaze, the doctor’s question needs to be ambiguously addressed to either the patient or companion. In this example, the explicit speaker selection (in the question design) conflicted with the embodied speaker selection (in the gaze), and that conflict caused a long silence due to the ambiguity of who the next speaker should be.

The reason for the doctor’s shift in gaze at line 21 (Figure 3.21) can be identified in the prior sequence. The companion had been the primary contributor from line 01, and it had been established within the talk that the patient had difficulty with memory during and after the seizures (lines 03-11). This means that the patient might have had difficulty answering the question on lines 20-21, leading the doctor to invite the companion non-verbally even after questioning the patient verbally.

It is now worth considering some examples of embodied invitations as they are used by patients. Overwhelmingly, patients use embodied invitations when they are visibly struggling to answer the doctor’s question and wish to recruit the companion’s help in answering. In this sense, they are similar in function to the explicit functions that we saw in the previous section. An example can be seen in extract 12.

Extract 12: [162 : Spouse:1.32](Sunday)

```
01          (1.0)
02    Doc:  so these- (.) when when when was your last seizure?
03          (1.2) ((patient turns to companion: Figure 3.23))
04    Com:  su:n:day
05    Pat:  sunday
06          (0.2)
07    Doc:  hmmm
08          (3.6)
09    Doc:  what can you tell me about that
```

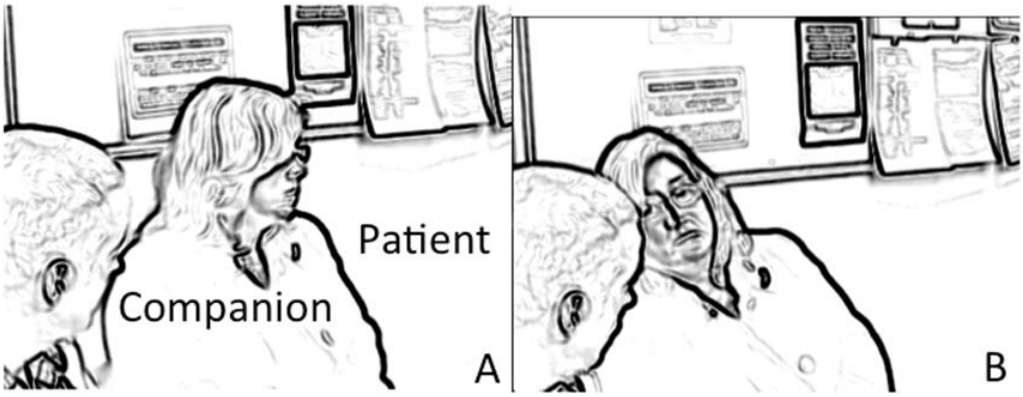

Figure 3.23 patient turns to companion.

The target lines here are lines 03-04. The patient did not respond to a question which is directed at her ("When was your last seizure"), instead slowly turning to look at her companion (Figure 3.23). Her not answering, combined with the head turn to the companion, acted as a recruitment, which lead to the companion answering for her at line 04. By repeating the companion's contribution (line 05), the patient took ownership herself of what he had said.

A similar example can be seen in extract 13, which also features a patient recruiting a companion through displays of difficulty and gaze.

Extract 13 [170: Spouse: 1.55] (I can usually tell when it's starting)

```
01    Doc:  And you remember how they first started?
02          (0.2)
03    Pat:  I just don't feel ri:ght I just don't feel meself,
04          I fee:l (2.2) >a bit light-headed<. How can I explai:n=I
05          don't- >a bit bit< light-headed off- just don't feel
06          right in mese:lf.
07    Doc:  Mm hmm.
08          (0.6)
09    Pat:  An:: ((Turns to look at Companion)) (Figure 3.24)
10          (0.7)
11    Com:  °(and) you know° I I: can usually tell when it's starting
12          because she starts to slur her wo:rds.
13    Doc:  What before you can tell.
14    Com:  I can te:[ll.]
15    Pat:           [He ]can=aye.
16    Com:  I can tell when they're coming on cos she'll- like her
17          talking starts to get a bit la:boured and a bit slu:rred.
```

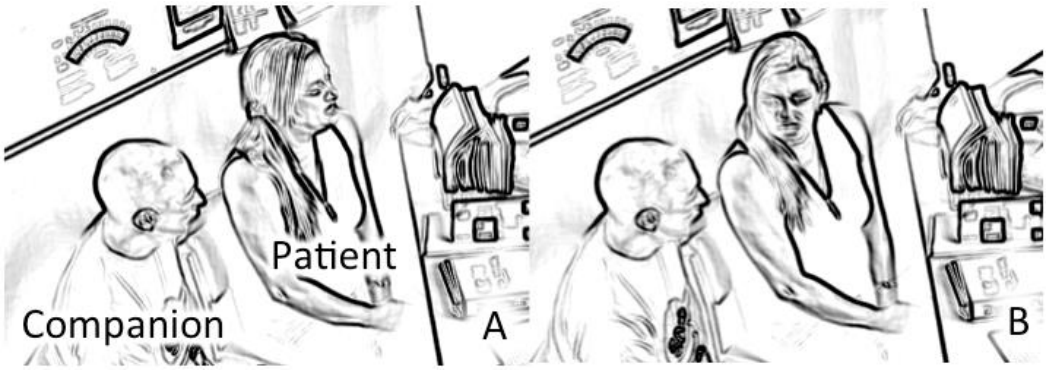

Figure 3.24 patient turns to companion

There are multiple features suggesting that the patient was struggling to answer at lines 03-06. These include her use of "just" ("I just don't feel right", "I just don't feel myself"), indicating that she struggled to describe a concrete sensation; her elongation on "feel" at line 04, followed by a pause, which indicated a word search (Clark & Fox Tree, 2002); and, most explicitly, her saying "how can I explain" at line 04, which signalled her difficulty in producing a description of how her seizures first started.

After a silence at line 08, the patient started talking again at line 09, with an extended "And". This was elongated, which, again, signalled a word search (Clark & Fox Tree, 2002). It was also followed by a silence (leaving her turn incomplete), and accompanied by her turning her gaze to the companion (Figure 3.24). It was the combination of these features (an unfinished turn and a shift in gaze) that invited the companion to contribute. He did so at line 11, describing a symptom (slurred words) that typically marks the onset of a seizure.

Extract 14 features a similar recruitment to extracts 12 and 13, with the patient using both her gaze and displaying difficulty in answering. In this case, as well, the patient explicitly states that she is unable to answer the question.

<u>Extract 14 [173: Parent: 2.43] (She was lying still)</u>

```
01    Doc:  And< then you fell to the floo:r?
02    Pat:  Yes. (1.0) Well me brother said I slid, cos I got hold
03          of the wa::ll and sli:d do:wn and just fe:ll.
04          (0.2)
05    Doc:  Mm:.
06          (0.4)
07    Pat:  And that was it.
08          (0.8)
09    Doc:  So did your brother describe any shaking? with that
10          fi:rst attack, or were you just lying sti:ll.|
                                                          |Figure 3.25A
11    Pat:  I| don't kno:[w.]
             |Figure 3.25B
```

```
12    Com:                [°N]o.° She was lying still=I was to::ld.
13    Doc:  Mm:.
14          (0.3)
15    Com:  >And he didn't know what to do(=cos she:)< Mo:re or
16          less as she went into it she came out of it=>but she
17          were< groggy .h[hh  when  she  was  comi:ng.  ]
18    Doc:                 [Oh right, so you weren't out f]or very
19          long?
20    Com:  n-No: it w[asn't a   long      ti:me ]=
21    Pat:            [It was about two or three:]=
22    Com:  =[i-  Y e  a  h    (°no ]not a long time°)
23    Pat:  =[ (°minutes wasn't it°)]
24    Pat:   (not a long time.)
```

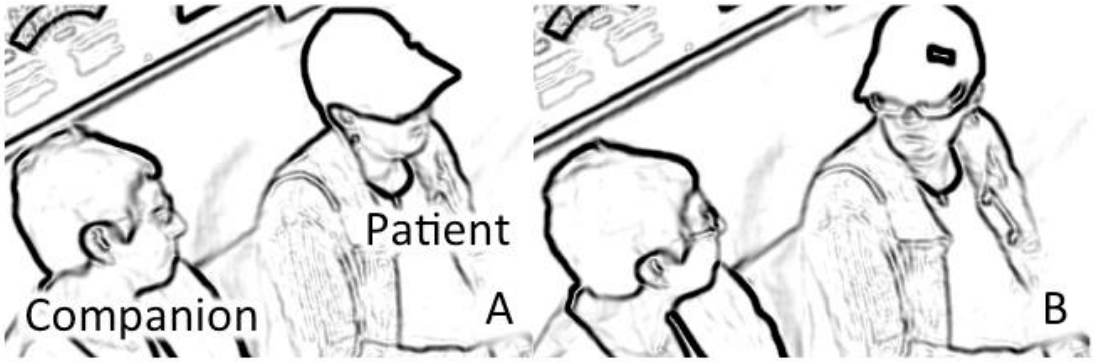

Figure 3.25 patient turns to her companion

In this extract, the doctor was questioning the patient about an incident witnessed by the patient's brother (who is not present in the consultation). The patient displayed difficulty in answering this question, however, turning her head to the companion (her mother) and saying, "I don't know". As in previous examples, a display of difficulty coupled with gaze invited the companion's contribution (Figure 3.25).

4 Volunteering

Companions volunteered to contribute 42.6% of the time. Cases were coded as volunteering when the companion self-selected as next speaker in the absence of explicit invitations (as illustrated in section 2), or embodied invitations (as illustrated in section 3). Companions do not volunteer to contribute to talk randomly but do so in specific sequential contexts. These contexts demonstrate how the companion is orientating to the patient's primary rights to respond to the doctor, and to the phases of the doctor's consultation.

This section is organised into 3 subsections. The first subsection examines instances where companions volunteer to talk after the patient has answered, including cases where the companion adds to the patient's answer, and cases where they move to correct the patient's answer. The second subsection examines instances where companions volunteer to answer

instead of the patient, and the third examines instances where the companion initiates new actions in the consultation, usually by asking questions.

4.1 After the patient's answer

A common point for companions to self-select was immediately after the patient's turn. In this space, they tended to either endorse, confirm, or correct the patient's prior answer. An example of a companion confirming and adding to a patient's answer can be seen in extract 15.

Extract 15 [155: Spouse: 2.30- 2.48] (He hardly drinks now)

```
01    Doc:  A:nd something about your liver and alcoho:l.
02          °w-° What's the problem there:?
03    Pat:  I was drinking e:r fa:r too much=at one time.
04    Doc:  And you've cut down no:w?
05    Pat:  I've cut ri:ght down.
06    Com:  He hardly drinks |no:w.
                             |Figure 3.26
```

Figure 3.26 sustained gaze not at the companion.

The companion in this extract has not been invited, either explicitly or through gaze, to contribute. The doctor's questions were directed at the patient (note the pronouns "you" and "your"), the patient does not recruit the companion in his response, and neither parties' gaze was directed at the companion (Figure 3.26– note that the companion is off-camera).

Despite this lack of recruitment, the companion volunteered a contribution at line 06 ("He hardly drinks now"). Prior to this turn, the patient answered the doctor's question about whether he had "cut down" on his drinking by affirming he has "cut right down". Given that the patient's drinking is something that the companion would have witnessed, she is able to confirm what the patient has said. The companion's volunteered contribution here thus corroborates the patient's claims of reducing how much he drinks, establishing him as a "good patient".

Extract 16 is another example of the companion voluntarily adding to the patient's turn. The extract begins during the patient's problem presentation.

Extract 16 [170: Spouse: 1.25] (They can come quite quickly)

```
01    Pat:  Ye::ah (0.2) but it's not ni:ce living- wondering
02          whether one da:y >you know< wondering from day-to-day you
03          kno:w. (0.1) I always carry me pho:ne with me all the
04          ti:me >cos the doctor said that<=but someti:mes it gets a
05          bit of a bi:nd >you know<.
06    Doc:  Mm:.
07    Pat:  It's not a nice=it's not a nice li:fe to live
08          real[ly.|]
09    Com:      [The|]y (can) come on |quite quickly °can't they?°
                  |Figure 3.27      |Figure 3.28
10    Pat:  Ye:a|h, they come on really quick.
                |Figure 3.29
11          (0.2)
12    Doc:  Mm hmm.
```

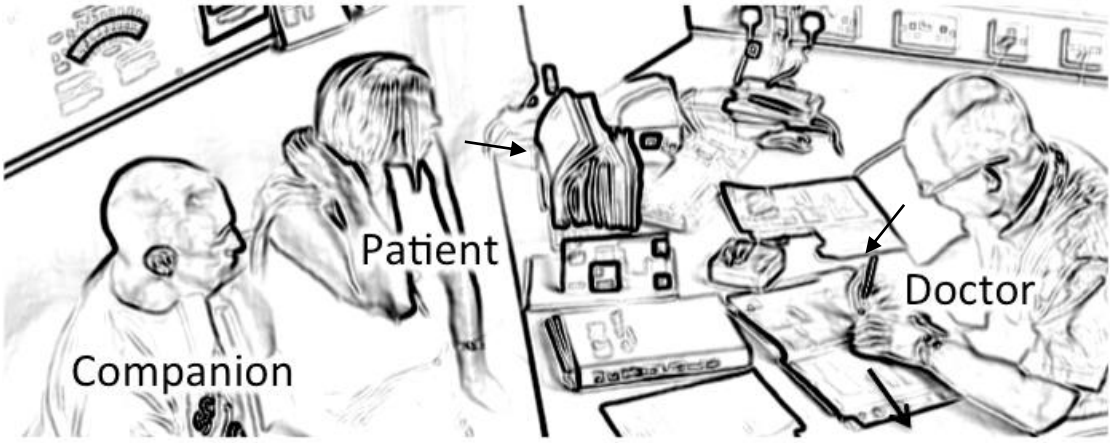

Figure 3.27 The patient and the doctor are both not looking at the companion as the companion starts talking

Figure 3.28 The patient continues to not look at the companion, as he talks but the doctor

glances up.

Figure 3.29 Both the patient and doctor are not looking at the companion.

The key turn by the companion is on line 09, which came, like in extract 15, after the patient had spoken. In her turn (lines 01-05), the patient talked about the effect that her seizures were having on her quality of life, particularly with her uncertainty about when the seizures will happen. She provided the upshot of her talk on lines 07-08 ("It's not a nice life to live really"), which also signalled that her problem presentation might be coming to a close.

It was at this point that the companion self-selected to speak, in slight overlap with the patient: "They (can) come on quite quickly can't they?". His response provided detail that supported the upshot of patient's problem presentation, suggesting that the seizures come on quickly and, as such, unpredictably.

At line 08 and the beginning of line 09 as the companion starts to speak, both patient and doctor are not looking at the companion (Figure 3.27), the patient is looking at the doctor, and the doctor's gaze is on his notes. As the companion speaks the doctor looks up (Figure 3.28), at the companion, the timing suggests the doctor's gaze did not invite the companion's contribution, but that the shift in gaze is in response to the companion self-selecting to speak.

The companion also ended his turn with a tag question, calling upon the patient to confirm his contribution. The patient provided this confirmation at line 10, first with an agreement ("yeah"), then by repeating his turn almost verbatim. This showed that the patient agreed with the companion's contribution by taking ownership of it herself. This is similar to how patients confirmed companions' contributions in sections 1 and 2, above (see particularly extract 1 part 2(also extract 12) and extract13).

Sometimes the companion's contribution did not come immediately after the answer but still responded, or added, to the patient's turn. This can be seen in extract 17, where the companion contributes to the patient's answer after a silence.

Extract 17 [162: Spouse: 6.30](Which happened again...)

```
01    Doc:  And the people who sa:w the attack, did they see any
02          shaking? or did you just collap[se ag]ai:n?
03    Pat:                                 [ No: ]
04    Pat:  .hh[h (    [I ]collap|sed) and I was stopping breathing=
05    Doc:     [   Hm.    ]      |
                                 |Figure 3.30((doctor starts writing))
06    Pat:  =Which (0.2) they had t[o resu]scita:te.
07    Doc:                        [Mm hmm]
08          (1.9) ((Figure 3.31. Doctor writing notes, Pat gaze down))
09    Com:  Which happened again in: >probably< pwhhh. ni:ne or ten
10          ti:mes in- during her s- stay in intensive ca::re. she-
11          she'd stopp she'd stopped brea:thing. (0.6) or so th-
12          (0.2) I think in hi:ndsight these were the seizures but
13          (0.6) they just treated it as apnoea='nd >resuscitated<
14          her at the ti:me.
```

Figure 3.30 The doctor starts writing notes.

The companion's contribution came at line 09. It came after the patient's answer to the doctor's question at lines 03-04 and 06, in which she described how she collapsed, stopped breathing and had to be resuscitated after a seizure. The patient shifted her gaze down at the end of this turn (Figure 3.31). The doctor, meanwhile, was writing notes from line 05 onwards (Figure 3.30), continuing to do so through the latter half of the patient's response (Figure 3.31). As such, neither the patient nor the doctor were gazing at the companion when he

began his contribution at line 09.

Figure 3.31 The doctor continues to write notes and the patient's gaze cast downwards

The companion began his contribution with "which", indicating that he was adding to the patient's turn rather than introducing a different topic. His addition supported the patient's account and upgraded the severity of what happened by describing that she needed to be repeatedly resuscitated "probably nine or ten times." In this example, therefore, the companion's contribution was facilitated by the extended silence created by the doctor writing his notes. The patient herself could, of course, have used this silence to expand upon her answer. That she did not do so meant that the companion was able to use it himself to come in and add to her account without the risk of interrupting.

Aside from adding to patient's accounts, companions can also come in to offer correction. They can do so either by contesting the details of an account (usually times, dates, or locations or seizures), or by adjusting the reported severity of symptoms. I will focus here on the former type of correction because the latter will be covered in greater depth in a later chapter. In the following extracts none of the corrections were explicitly invited or invited through gaze by the patient or the doctor. The companions in each extract orientated to a perceived trouble source in the patient's turn, and self-selected to correct the patient's answer. Therefore, understanding what the companion was correcting, is important in understanding how they came to self-select.

There are two corrections by the companion in the following extract; at lines 19 and 31. The first adjusts slightly the time that has been reported, and the second contests where the seizure took place.

Extract 18 [096: Spouse: 2.01-2.32] (Ish)

```
01    Pat:  ah ha ha the only thi:ng I kno:w as I came too: I got
02          this buzzing in my head.
03    Doc:  Right
04    Pat:  and I could hear my wi:fe in the distanc:e (0.5) saying
05          saying (( pat name)) (( pat name)). (0.6) And that's a:ll
06          I know about it but (0.2) ((com's name)) can tell ya
07          (0.6) more about it. (0.9) cant ya?
08          (0.2)
09    Doc:  OKay ta- ah t t t take us from the beginning what was
10          the: e:r (0.2) >what was the sequence of events.< Just
11          tell me er as much as you can remember on what
12          happened u- leading up to this.
13          (1.2)
14    Pat:  Well I walked into roo:m and sat down in chai:r and
15          th[e    n  e  x  t:]
16    Doc:    [And >this was at] four o'clock in the afternoon,
17          was it?<
18    Pat:  Yeah the[n nex-]
19    Com:          [ I: : ]sh
20             (0.8)
21    Pat:     And then (0.2) n[ e x : : ]
22    Doc:                     [You walke]d into the living room.
23             (0.2)
24    Pat:     Yea:h.
25             (0.2)
26    Doc:     An[d yo-]
27    Pat:       [S a t] sad do:wn into=
28    Doc:     =Had you just got up? O::r
29             (0.4)
30    Pat:     No::,  no[:↓: : ]
31    Com:              [You WE]nt into KItchen ((pat's name)).
32    Doc:     hm
33    Pat:     Yeah,
34             (0.5)
35    Doc:     >So you went< into the kitche:n=came back >into the<
36             living room.
37    Com:     Tha[t's  ]it.
38    Pat:        [Yeah.]
39             (0.4)
40    Doc:     Okay?
```

Both of the companion's contributions (lines 19 and 31) here came in post-transition space overlaps (Drew, 2009). In line 18, the patient's turn was projectable as complete after the "yeah", and in line 30, the patient's turn was projectable as complete after the first "no" and so after these utterances is a transition relevant place. The companion's turns were in overlap because, in both cases, the patient continued to talk.

The first correction at line 19 adjusted the time suggested by the doctor at lines 16-17 ("four o'clock") by making it more approximate: "ish". This performed the dual function of adjusting both the accuracy of the time itself and the patient's agreement with that time at line 18.

The companion's second correction in extract 18 (at line 31) is more substantial. In it, the companion corrected the narrative of the patient's seizures that was developed in the preceding turns by suggesting that he walked "into the kitchen" instead of "the living room". While the doctor did not directly ask the companion to expand upon this correction, he did incorporate it into his next question to the patient (at line 35) by asking him to confirm the revised narrative ("So you went into the kitchen…"),

Extract 19 is an example of the companion correcting diagnostic description in the patient's account during the problem presentation phase. Rather than coming in overlap, the companion's correction in this example comes after a 0.3 second pause.

Extract 19 [083: Parent: 02.16-03.00] (Water infection)

```
10    Doc:  So how long have they been going on fo:r,
11    Pat:  U::m (0.8) When I was younge:r I had a series
12          of fai:nts but the:n it started again when I was
13          like eightee:n.
14          (0.2)
15    Doc:  So two yea:rs.
16    Pat:  Yeah. It was: it started whe:n my mum and dad were
17          going through a divo:rce. A::nd the doctor fi:rst
18          put it down to stre:ss  (0.8) like my body was just
19          (0.3) overworked, and the:n_ I'd had that i:n
20          November two thousand and ei:ght, (0.3) And then in
21          february: .hh ur:m I had like my first
22          blackou:t.(0.4) A:nd I wa:s (.) vomiting. I cou-
23          couldn't stop vomiting=co[uld] I:,
24    Com:                           [Mm.]
25    Pat:  But then I went tu:h (0.4)((hospital na:me)) and
26          they did blood samples cos they thought I might be
27          diabetic..hhh and then it were fi:ne.
28          (0.3)
29    Com:  But you'd got a water infection.
30    Pat:  I'd got a water infe[ction.   ]
31    Doc:                     [So with t]he fi:rst o:ne
32          there's a water infection.
33    Com:  Yes.
34    Pat:  Yeah.
```

The target line in this extract is line 29: "But you'd got a water infection." It came after the patient had, in response to the doctor's question, given an extensive account of her seizures, mentioning a blood test she had had done (line 26) because of a possible diagnosis of diabetes (line 27). While the patient made it clear that she was not diabetic ("they thought I might be

diabetic .hhh and then it were fine”), she did not state what the problem was instead. The companion thus, after a 0.3 second gap, self-selected to provide that information, using the word “but” to connect her turn to the patient’s turn while also indicating that it was in contrast to something that she, the patient, had said. The patient took ownership of this correction by repeating it at line 30 (“I’d got a water infection”), and the doctor incorporated it into his next question at lines 31-32.

Another common way in which companions corrected patient’s descriptions of their seizures was to correct situational details around seizures. These were often contextual details like times, dates, or where precisely the seizures took place. Extract 20 is an example of the companion correcting a detail about *when* the seizure took place, as well as accounting for why the time was significant.

Extract 20 [091: Spouse: 07.06-07.56] (It was the morning)

```
01    Doc:  Did anyone see: (0.9) thi:s (.) collapse?
02          (0.5)
03    Pat:  I I: was walking by myself.=>there would have-<
04          it was about three o’clock in the afte:rnoo:n=
05          there would have b[e e : n      .h  h  h] one=
06    Com:                    [°It was the morning.°}
07    Pat:  =or two people, (Sorry?)
08    Com:  It was th[e morning.]
09    Pat:          [(Oh     ri]ght) it was the morning. It
10          was the morning. U:::m (0.5)
11    Com:  Yes there was [some]thing going on in the=
12    Pat:                [ No,]
13    Com:  =showground=so there was lots of people aro:und.
14          (0.7)
15    Doc:  But you can’t remember what they said?
```

The target lines in this extract are line 06 (“It was the morning”) and its repetition at line 08. Prior to these lines, the doctor asked the patient if anyone saw him collapse. In his answer at lines 03-5, the patient did not say directly if there was, but did use the time at which it occurred (“three o’clock in the afternoon”) as a reason why there would have been “one or two people” present.

The companion’s turn, in overlap with the patient at 06, contests the time that the patient has suggested. The patient repeats this at line 08, following what sounds like an open repair initiation (Drew, 1997) from the patient at line 07 (“sorry?”). As in previous examples, the patient took ownership of the companion’s correction by repeating it, thus amending his narrative. His “oh right” before the repetition, meanwhile, claimed a change in cognitive state (Heritage, 1984a).

At lines 11 and 13, the companion went on to explain that “there was something going on in the show grounds, so there were lots of people.” Rather than just correcting the time detail, then, her correction also had implications for the number of people who witnessed the seizure (which was the original focus of the doctor’s question). The patient overlaps with the patient at line 12 (“No”) indicating there may have been some disagreement, but he did not continue. The doctor, meanwhile, does not incorporate either version of the narrative into his next question, except to design it to assume that there was *someone* there (line 15) who saw the seizure.

In each of these extracts, the companion’s volunteered to participate in the consultation in order to correct, or adjust something about the patient's answer. They are not invited, explicitly invited or invited through gazeby the patient or doctor, but orientate to something in the patient’s answer that they perceive needs to be corrected or have more information added to it.

4.2 Answering instead of the patient.

Another place in which companions volunteered (self-selected) in these consultations was by answering instead of the patient. There were many circumstances that could facilitate this, including the patient visibly struggling to answer for themselves, the companion having been invited to talk earlier in the consultation (although not necessarily in relation to the current line of questioning), and the companion having shared knowledge on the topic at hand (e.g. their relationship with the patient, children they had with the patient (when the patient was their spouse)).

In extract 21, the target contribution comes immediately after a previous utterance where the companion was invited to talk by the patient.

Extract 21 [156: Parent: 1.36] (End of August-September)

```
01   Doc:   Oka:y and when was the fi:rst one?
02   Pat:   Wa- was it no:w just- aft[er      summ]e:r.
03   Com:                           [(september )]
04   Pat:   September were[n’t  it],=Yea:h,
05   Com:                 [ Yeah. ]
06   Doc:   Was it Septemb[er, o]:r o:r?
07   Com:                 [yeah ]
08   Com:   Well e:nd of August=September something like th[at.
09   Doc:                                                  [Mmhm,
10          (2.5)
11   Pat:   It w[as ((   )).]
12   Doc:       [   So   wha]t what about the first one=what were
13          you doing at the ti:me?
```

This extract has been used previously to show an example of the companion being invited to talk through the patient's gaze (extract 8). In this section, the focus is on the companion's next contribution at lines 07-08. The reason for reusing the extract is to show the difference between what the coding measured, which was each of these utterances in isolation, and what conversation analysis shows, which is how these utterances sequentially relate to each other.

In this case, the patient had recruited the companion (through gaze and a tag question) to help answer the question at line 04. This meant that, when the doctor asked a clarifying question at line 06, the companion had already been invited into the discussion by the patient, giving her greater entitlement to answer. This entitlement can be seen in how the companion responded immediately at line 07, without waiting for the patient to respond. While the patient did try to add something to this response at line11, she did so only after a 2.5 second pause. The patient's addition was also cut off by the doctor asking the next question, suggesting an orientation on his part to the companion's right to answer.

Extract 22 is another example of the companion answering instead of the patient. The topic here is some tests that were done for which they do not yet have results. The patient mentions that according to another doctor he has had some tests that came back normal.

Extract 22 [0090: Spouse: 12.04] (No they thought-)

```
01    Doc:  So they've not given you any: results of these tes[ts.
02    Pat:                                                    [No] I
03          went to my doctor's: (0.5) °>when did I go to me
04          doctor's? <Last- last week°.=We[ren't it.]
05    Com:                                 [(on   Thu]rsda[y.)[(   )]
06    Pat:                                                [See cos I]
07          had to get me sick no:te exte[nded.] You see:.
08    Doc:                               [Yeah,]
09    Pat:  .hhh And he- And he seemed to reckon that my: (.) some of
10          my results have come back as no:rmal.
11          (0.2)
12    Doc:   Ri:g[ht.
13    Pat:       [Whether he'd got my result from (.) hospital I
14          don't know. .hhh but he seemed to think that they was
15          <normal.>  (0.7) But (0.3) he said >obviously< an head
16          specialist >obviously< cos I've (0.5)  °s- #h#° got this
17          appointment.
18    Doc: .hhh So[:.]
19    Pat:       [Th]at.
20    Doc:  It °#eh h h#° We:ll Hhhhhh. wh- why: were you admitted to
21          the eye dee: ((ID)) tea:m? do you know↓. Er, did you have
22          a TEmperatu::re? o:r_ ((Figure 3.32))
23    Com:  No: they th[o u : : g h t    y ou'd  got   a : ][: :   ]
24    Doc:            [Did they think you had an infection][      ]
25    Pat:                                                [ d- d-]
26    Pat:  They thought I'd got an infection on me brai:n. >This is
```

```
27          why they thought I'd ha[d that< sei-]
```

Figure 3.32 Both the doctor and the patient are not looking at the companion as the doctor finishes his question at line 22.

The target line in this extract is line 23. Prior to this, at lines 20-22, the doctor asked the patient to expand upon his trip to see the hospital ID[7] team. This question was clearly directed at the patient (notice the doctor's use of "you" and his gaze in Figure 3.32), with no indication that the companion was being invited to answer.

The companion did self-select answer, though, coming it at line 23 to state that "they thought you had a-." Her turn was cut off by the doctor, who came in in overlap at line 24 to ask the patient another question: "did they think you had an infection." While this question appears to ignore the companion's contribution, the timing of the overlap means that it is possible that the doctor heard the companion's turn as he was formulating his question and incorporated "thought" into his question design. Certainly, the topic of the doctor's question is similar to where the companion's contribution was projectably leading. This extract thus shows how the patient, doctor and companion co-construct the companion's right to answer, with the doctor immediately shifting the focus back to the patient after the companion has self-selected while still incorporating the companion's contribution into the consultation.

In extract 23, the companion volunteers to answer after having introduced the topic under discussion.

<u>Extract 23 [162: Spouse: 2.23] (Fittings and convulsions)</u>

```
01    Doc:  what can you tell me about that
02          (0.8)
```

[7] From context, this is probably an acronym for "Infectious Diseases".

```
03    Pat:  u:m I don’t really remember a lot about them
04    Doc:  mm hmm
05    Pat:  u:m (4.0) kind of very very tired afterwards=don’t really
06          remember the event befo:re (1.4) leading up to it.
07    Doc:  mmm
08    Pat:  ahm  (2.4) obviously while I’m having a seizure I never
09          remember what happens during a seizure, (1.6) and then
10          normally I need to just sleep
11          (5.4)
12    Com:  quite often a lot of vomit well some
13          vo[miting afterwards as w]ell=
14    Pat:    [ye:ah vomiting        ]=
15    Pat:  =quite bad heada:ches
16          (4.0)
17    Doc:  and when is the vomiting, immediately afterwards?
18          (1.8)
19    Com:  pretty much yeah (0.4) once you’ve stopped sort of the
20          fittings and convu:lsions she (  ) come rou:nd slightly
21          (0.4)
22    Doc:  (.hh )but you're aware of the vomiting are you,
23    Pat:   no not always
```

The focus of this extract is line 19. Prior to this, at line 17, the doctor asked about a topic (vomiting) that the companion raised at lines 12-13. The companion’s entitlement to answer was thus increased because it is on record that he knows about this symptom. Even so, the long silence before the companion answers on line 18 means that the patient was given time to answer herself before the companion steps in to answer for her. The companion also oriented to the patient’s right as primary respondent in the way that he initially addressed his answer to her rather than the doctor (“once you’ve stopped”; note that he does change pronouns to the third person at line 20, however). The doctor, meanwhile, oriented to the patient’s primary respondent rights by addressing his next question to her at line 22 (“but you’re aware of the vomiting are you”). Note how this enquiry also addressed the patient’s failure to answer previously by asking her to confirm whether she was aware of the vomiting.

In this section, we have seen several examples of companions volunteering to answer instead of the patient. Out of context, volunteering like this would appear to show less of an orientation to the patient’s rights as primary respondent. However, as we saw in extract 23, there are often sequential features that give the companion greater entitlement to answer instead of the patient. Furthermore, the companion in that extract still oriented to the patient as primary respondent.

In cases like extract 22, meanwhile, where the companion was not as observant of the patient’s rights as primary respondent, there was still an element of co-construction between the patient, companion and the doctor. Specifically, the doctor in that case continued to orient

to the patient's primary right to answer while still incoporating the companion's contribution into their talk.

4.3 Asking questions and initiating actions

The last kind of volunteering contributions companions tended to do was to initiate actions, mainly by asking questions. These types of contributions tended to occur near the end of consultations (after diagnosis) and at points where other phases of the discussion had ended, creating sequential opportunities for companions and patients to raise topics or concerns of their own.

Extract 24 features two examples of such contributions. In the first, the companion asks for advice about what she should do if her son should have another seizure. In the second, she asks for information about an MS nurse and for a medical bracelet that her son could wear.

Extract 24 [156: Parent: 26:30] (So what would you recommend?)

```
01    Doc:  =regularly: >you know<, u::m the idea: with treatment
02          is that we give you um: that we protect you,=So >that
03          that< eh >you know< if stuff happe:ns >that that< might
04          make it more likely you have a seizure, >you know< you
05          have a temperatu:re or an illness you can't sleep you
06          travel .hhh that you're protected. (.) yeah?
07    Pat:  °Mm.°
08          (2.6)
09    Com:  So what would you recomme:nd?=So >you know,< if he: has
10          another sei:zure at ho::me.=Would you recommend we dea:l
11          dea:l with it at home or ring ring the ambulance again?
12    Doc:  U:m you you don't really need to ca:ll an
13           ambulan[ce_ a]:nd if the seizu:re u::m seems to be:: er=
14    Com:          [Yeah.]
15    Doc:   =settling at at um er y'know ↓well five six
16          seven m[i minutes. y'know] if it seems to be=
17    Com:         [  Minutes  yeah. ]
18    Doc:  =subsiding th[en. ]
19    Com:               [Yeah] yeah.
20    Doc:  .hhh U:m e#hhhhh# actually Most epileptic seizures u:m
21          even the prolo:nged one:s u:m .hhh er the shaking stops.
22          It's just that the:n the person starts to shake again
23          af[ter a few minutes. I]f that happens you do have to=
24    Com:    [Yeah    yeah    yeah]
25    Doc:  =call an ambul[ance.]
26    Com:                [Right]
.
.
[45 lines omitted]((doctor explaining his answer in more depth))
.
.
71    Doc:  U:m I will put you in touch with the epilepsy: nurses u:m
72          (0.8) who: u::m  (0.5) a::h can give you some more
```

```
73          information a[bout wh]at to do. And they've got leaflets=
74    Com:                [ Yeah. ]
75    Doc:  =as well. .hhh[h And the]n if there is another seizure=
76    Com:                 [  Y e s. ]
77    Doc:  =>(also)< you can contact them and a:sk them
78          what [to do]:,
79          Com: [Yeah.]
80    Doc:  Yea[:h,        ]
81    Com:     [  ( on ) (y]eah)
82          (2.7)
83    Com:  Do you still hav:e (0.3) Em Ess ((MS)) nurses?
84    Doc:  We do[:,]
85    Com:       [ Y]ou kno:w. (0.5) Cos we: have not we:ll.
86    Pat:  ( u guys) (wouldn't) get in touch with them.
87    Com:  That's it.
88    Pat:  Yea:h.
89    Com:  We've not seen one for yea:rs. (0.6) at least two
90          years.=We don't know who to contact for any a[dvi:c]e=
91    Doc:                                                [Okay ]
92    Com:  =o:r anything.=We used to have one but (0.5) they jus:t
93          Went.
94          (0.4)
95    Doc:  Well they're still around if um:_
96          (5.3)
97    Pat:  There a:re_ we've had courses with them, awareness
98          courses=stuff like that [(o:r)
99    Doc:                          [I can contact the em ess ((MS))
100         nurses >as well< and tell the[m  t o ] to: um (js) write=
101   Com:                                [Please.]
102   Doc:  =to you again with their contact details.
103   Com:  Mm
104   Doc:  Yeah?
105         (0.7)
106   Doc:  U[:m.    ]
107   Com:   [And One] more Thin:g >do you know like< whe:n (0.7) he
108         goes ou:t on his o::wn_ is there anything he can carry=
109         what you gi:ve? that sa:ys "suffers from epilepsy"?=or
110         would we have to go out and (0.2) research to buy
111         someth[ing ourselves?
112   Doc:  U::m You- you can bu:y bra:celets >for instance< or
113         chai:n[s, U:]mm which e:r and then you can enter=
114   Com:        [Yeah.]
115   Doc:  =information on these chains. .hh The epilepsy nurses
116         have information about that,=The[re's a]lso  plenty of=
117   Com:                                  [ (mm) ]
118   Doc:   =stuff on the Internet if yo- i[f you  l]ook.
119   Com:                                  [°Right.°]
```

This extract is part of an extended sequence where the companion asked questions related to her son's care. It is illustrative of how she initiated the topic and held the floor as an active participant as the doctor answered.

The first point of interest is the companion's turn at lines 09-11. This line was preceded by a 2.6 silence in which neither the doctor nor the patient took the opportunity to either continue the previous topic or initiate a new one. This left the floor open for the

companion to initiate a new topic by asking what the doctor recommended she should do when her son had a seizure.

```
05          have a temperatu:re or an illness you can't sleep you
06          travel .hhh that you're protected. (.) yeah?
07    Pat:  °Mm.°
08          (2.6)
09    Com:  So what would you recomme:nd?=So >you know,< if he: has
10          another sei:zure at ho::me.=Would you recommend we dea:l
11          dea:l with it at home or ring ring the ambulance again?
12    Doc:  U:m you you don't really need to ca:ll an
13           ambulan[ce_ a]:nd if the seizu:re u::m seems to be:: er=
14    Com:          [Yeah.]
15    Doc:   =settling at at um er y'know ↓well five six
16          seven m[i minutes. y'know] if it seems to be=
17    Com:         [  Minutes  yeah. ]
18    Doc:  =subsiding th[en. ]
19    Com:               [Yeah] yeah.
```

As part of her question (lines 09-11) the companion proposed two courses of action: to deal with the seizure at home or to ring an ambulance again. Her question initiated a longer sequence (from lines 12-73) in which the doctor explained what the companion should do in a generic, depersonalised way (e.g. "the person starts to shake again", lines 20-23). This allowed him to distance the discussion from the patient himself and to direct his answer at the companion. Notably, the patient did remain silent through this sequence, suggesting that all parties oriented to the companion as the active respondent at that moment.

The companion's second key contribution in this extract was at line 83. This occurred as the prior topic came to a close, with the doctor offering to get the companion in contact with an epilepsy nursing service

```
      .
77    Doc:  =>(also)< you can contact them and a:sk them
78          what [to do]:,
79          Com: [Yeah.]
80    Doc:  Yea[:h,        ]
81    Com:     [  ( on ) (y]eah)
82          (2.7)
83    Com:  Do you still hav:e (0.3) Em Ess ((MS)) nurses?
84    Doc:  We do[:,]
85    Com:       [ Y]ou kno:w. (0.5) Cos we: have not we:ll.
86    Pat:  ( u guys) (wouldn't) get in touch with them.
87    Com:  That's it.
88    Pat:  Yea:h.
```

Like the first instance in this extract, the companion's utterance at line 83 was preceded by a silence indicating that the previous topic had ended. At line 83, the companion asked whether

they “still have MS nurses”, explaining that they have had difficulty contacting them in the past. The doctor, at lines 99-102, offered to get in touch with the MS nurses on their behalf, which the companion accepted at line 101 (“please”). As in the previous example, the patient remained largely passive throughout this sequence, contributing only at lines 86, 88 and 97-98. As such, the companion was again the primary interlocutor here, which was most apparent in her being the one to accept to the doctor’s offer. This is noticeably different from previous sections, where the companion’s role was peripheral to the primary interaction between doctor and patient and shows a sequential environment where the companion can and does become the primary interlocutor.

The third instance of interest in this extract (line 107-111) came after the acceptance of the doctor’s offer. It once again occurred at the end of a topic and once again was preceded by a long silence (0.7 seconds on line 105). In this space, both the companion (line 107) and the doctor (line 106) self-selected to speak. The doctor dropped off, and the companion went on to initiate a new topic.

```
105          (0.7)
106   Doc:   U[:m.    ]
107   Com:    [And One] more Thin:g >do you know like< whe:n (0.7) he
108          goes ou:t on his o::wn_ is there anything he can carry=
109          what you gi:ve? that sa:ys “suffers from epilepsy”?=or
110          would we have to go out and (0.2) research to buy
111          someth[ing ourselves?
112   Doc:   U::m You- you can bu:y bra:celets >for instance< or
113          chai:n[s, U:]mm which e:r and then you can enter=
114   Com:         [Yeah.]
```

The companion’s turn was formulated as a question but was also a request for a bracelet. The “or would we have to go out and research to buy something ourselves” was latched onto the end, projecting that this might not be something the doctor could provide. This projection turned out to be accurate, with the doctor recommending that they look online instead.

Extract 25 is another example of how a companion can use the end of the consultation to initiate discussion about issues that concern them. In this excerpt, the companion asks questions about the nature of the diagnosis the patient has been given.

Extract 25 [167: Spouse: 20.54] (Psychological)

```
01    Doc:   So (2.1) you know=I think these are non-epileptic
02           attacks, a:nd u:m anti-epileptic drugs don’t really (.)
03           help for non-epileptic attacks. .hh U::m (1.7) Just
04           taking them awa:y and pretending that nothing’s going
05           on .hh isn’t really going to be a way forward either.
```

```
06          U::m °>you know<° I wouldn't be surpri:sed if your
07          attacks got worse if you just stopped the tablets and
08          nothing else happens. (0.8) U::m I'm- I'm all fo:r
09          stopping the tablets, But >you know< in the context of-
10          of:(0.8) of u:m giving you treatment for non-epileptic
11          [atta]cks.
12    Pat:  [Mm. ]
13          (2.2)
14    Com:  Is most non-epileptic attacks psychology,=>whu
15          psychological.<
16          (1.2)
17    Doc:  mtch. Well, (0.7) U::m (0.8) Hhh. .hh What is
18          psychological, You see: (0.4) you kno[:w.]
19    Com:                                       [A- ] a- an event in
20          your lifdde that takes place that e:r disturbs you in some
21          wa:y=th[at um.]
22    Doc:         [Yeah, ]
23    Com:        °It-° it brings on an attack.
24    Doc:  Yes, U::m (0.4) >I think so,< But u::m °°meh orh°° a:ll
25          thi:ngs psychological still happen in the brai:n.
.
.
56 lines omitted
.
.

81    Pat:  [yea:h   but  at  the  ti:]:me e[:r  ] when that was
82          done (0.3) i:s e:r (0.8) I'd been living with a:: very
83          abusive partner for (0.8) e:r two years.
84    Doc:  Yeah<.
85          (2.1)
86    Doc:  Asymmetry: #ah# doesn't sound like this #ah# an effect
87          >especially< the fou:rth ventricle. #>I mean<# it it it
88          #u#:m (0.3) This sounds like poppycock >to be
89          honest<.=yeah? .hh U:m (0.9) the fourth ventricle is is
90          in a bit of the brai:n which you can't visualise very
91          well on the Cee Tee scan. (0.3) .hh u::m So: ehhh.
92          unfortunately #I I# Doubt= I Doubt that we'll ever get
93          that scan. >You know< I think we made an attempts to get
94          the scan °in the past from nineteen ninety eight°
95          [((   ))]. What we [  C a: n    d o : :.   ]
96    Com:  [((   ))]          [Can you do another one?]
97    Doc:  What we can do is do another sca:n,=and you know #ah# I
98          think many people have offered that. But the problem has
99          been that you we:re .hh u:m that that we thought you'd
100         be: u::m anxious in the em arh eye ((MRI)) scanner.
101         (0.5)
102   Com:  Yeah she w[oul]d yeah.
103   Doc:            [U:m]
104   Doc:  >You know< I'd be very happy fo:r for you to to have
105         another Cee Tee sca:n or an em arh eye: ((MRI)) scan um
106         if if that=
```

The target lines for this extract are lines 14-15 and 96, all of which feature the companion asking questions about the diagnosis. These questions came after the doctor had explained how the diagnosis affected treatment at lines 01-10. The first question (at lines 14-15) comes, much like the previous example, after a long silence.

This question, though somewhat related to the prior discussion, initiated a conversation about how non-epileptic seizures are psychological and what "psychological" means in this context. In his response at lines 24-25, the doctor oriented to the possibility that laypeople like the patient and companion may view non-epileptic seizures as less 'medical' in nature if they are caused by psychological trauma. He did so by reassuring them that all things psychological happen in the brain, meaning that the seizures, by implication, are still a medical issue. He then went on, in lines that were largely omitted, to expand upon this by explaining how non-epileptic seizures are linked to trauma.

The final turn where the companion initiated a question was at line 96. In this case, the companion was requesting a new scan ("Can you do another one?") in response to the doctor expressing "doubt that we'll ever get that scan" at lines 92-94. Notably, though, she did so in overlap with the doctor at line 97. This was a post-transition space overlap (Drew, 2009), with the companion self-selecting to speak at a point where the doctor's turn appeared to be complete but was in fact not. What is interesting is that the doctor was, with his turn, *also* proposing the idea of a new scan, meaning that both parties' talk was designed to shift the topic away from the old scan (which was unlikely) and onto a new potential course of action.

5 Discussion.

The aim of this thesis is, as was noted above, to examine the companion's role in the seizure clinic. Using a combination of coding and CA, this chapter has marked the first step towards this aim by giving an overview of how and where companions come to contribute in this environment. It has shown that companions are not generally treated as primary respondents; instead, they are oriented to as peripheral to the core doctor-patient interaction.

The chapter started out by showing that companions self-selected to talk 42.6% of the time and were invited to talk 47.8% of the time. Of these invitations, 20.2% were explicit and 27.6% were embodied. The chapter then used CA to analyse the sequential context around companions' contributions. This was structured around a spectrum, ranging from explicit invitations from the patient or doctor to self-selection by the companion themselves.

Companions were invited explicitly through turn design and gaze. There were differences in how doctors and patients issued explicit invitations. Doctors tended to use questions designed with pronouns, which were often accompanied by a shift in gaze to select the companion as the respondent. Patients, on the other hand, tended to use tag questions and gaze at the end of their own answers to doctors' questions, which recruited companions to

help them answer. Tag questions elicited minimal confirmations from companions, while longer questions elicited a more extended answer.

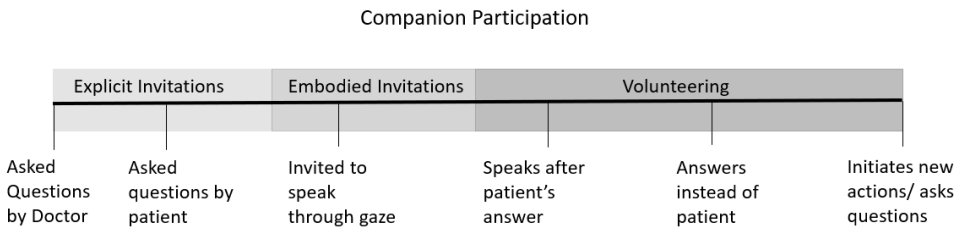

Figure 3.1 Gradient of ways in which companions come to participate.

Embodied invitations (i.e. invitations issued through gaze and other non-verbal features) tended to come more from patients than doctors. Patients used gaze, along with displays of difficulty in answering the doctor's question, to recruit companions' assistance. Because doctors tended to mostly ask questions, and to use question design to select the recipient, there were fewer instances of doctors using only gaze to invite companion's to contribute. This research thus reinforces existing literature (Holler & Kendrick, 2015; Lerner, 2003; Robinson, 1998; Tiitinen & Ruusuvuori, 2012) showing that gaze is used to coordinate participation in three-party medical interaction.

When companions volunteered (self-selected), they did so in several different contexts. They self-selected after a patient's turn, to add to, correct, or adjust the patient's answer; they answered instead of the patient when the patient was displaying difficulty answering (usually after a silence); and they initiated questions and new actions at the end of consultations, at points where the previous topic had come to a close. All of this shows that even when companions self-selected, they did so only when the sequential context called for it. In other words, companions did not come in in a disruptive, haphazard manner, but in a way that was sequentially sensitive, and co-constructed and managed by all parties (see also Stivers, 2001).

This chapter complements Robson, Drew, & Reuber (2013), who showed (using the same data) that when a companion was present, the patient talked less. It shows that, while patients may indeed talk less when a companion is present, this does not mean that the companion was talking over the patient, or otherwise eating into time that had been allocated to them. Instead, companions in this chapter acted as a resource that both the doctor and the patient could draw upon when the patient was struggling to answer for themselves (see also chapter 5). Answers to the question of whether companions take away from the time that

patients have to describe their seizures should thus to take into account the sequential placement of their contributions, rather than taking a purely numerical approach.

This chapter also complements Robson, Drew and Reuber's (2016) study on the role of companion. That study also looked at companion participation in this data set and found that companion participation correlated with NES patient's resistance to answering questions. This chapter offers a different, though not incompatible, interpretation of how companions come to contribute instead of, or after, the patient. This study provides context for that earlier study by looking at companion participation in phases other than history-taking, and beyond what may be relevant diagnostically. Robson, Drew and Reuber (2016) show, however, that companion participation, as well as being co-constructed in talk, may also be dependent on patient characteristics (e.g. their diagnosis, their personality, their age, their abilty and relationship to the companion). While this chapter shows how participation can be either invited or volunteered, it is possible that the levels of each type of contribution (along with the overall frequency of companion contribution) are influenced by such characteristics.

This chapter has provided an initial overview (both quantitative and qualitative) of companion participation in these consultations. With this in place, subsequent chapters will look in greater depth at specific aspects of this participation. This will begin in the next chapter, which will consider companions' corrections of patients' talk.

CHAPTER 4 UPGRADING CORRECTIONS

1 Introduction

The focus of this chapter is the contributions companions make to the interactions during seizure clinic consultations, especially to the ways in which the companion corrects or modifies information that the patient provides. In such instances the doctor asks a question and receives an answer from the patient, but the third party in some way amends, modifies or corrects the information provided by the patient.

This is of particular interest because one concern for neurologists in seizure clinics is whether the presence of a third party makes a difference, and what is that difference (Robson et al., 2013, 2016). In cases of correction, the doctor is given access to an alternative account or information to which he might not have had without the third party's contribution. This shows one way in which the third party presence can make a difference to the consultation. Some of the impact of these corrections will also be examined by considering the outcome of these corrections. The companion's turn is seen as correcting because the companion's intervention results in pausing the progressivity of the interaction (e.g. halting the progression of the series of questions in history taking) to correct something in the patient's utterance.

Correction has been widely studied in CA, although there is some ambiguity between what is known as repair and as correction in CA, these being overlapping concepts. Both are mechanisms which halt or impede the progressivity of talk. Schegloff, Jefferson and Sacks (1977) discussed their choice of using the word repair, on the grounds that correction was commonly understood to involve an error or mistake which is replaced by what is correct. Repair as a term is not contingent on there being an error, only that it is a mechanism of talk in which one speaker halts the progressivity of talk in order to edit or modify their turn, usually due to some trouble in hearing, speaking or understanding (Schegloff et al.1977). However, in the case of my data the phenomenon is specifically about what the companion is orientating to in the patient's turn of talk as being incorrect, rather than a case of trouble in hearing, speaking or understanding. For this reason, I have decided to use the term correction.

While I have looked at a variety of different types of corrections, this chapter will focus on a particular subgroup of corrections that was common. This subgroup is distinctive insofar as the nature of the correction follows a particular pattern, namely that the companion's correction upgrades the severity of the patient's answer. This can be either by providing a symptom when the patient does not offer one, or by increasing the frequency of a

symptom or event to increase the severity of it. This chapter will examine this phenomenon and the context in which it arises.

The correction comes in a three-part sequence;

1. The doctor asks a question
2. The patient answers in such a way as to downplay a problem with their health.
3. The companion makes a correction to the patient's answer, which upgrades the severity of the description of health problem concerned.

Each section of this chapter will focus on a different aspect of this pattern. The next section, section 2, will discuss the overall structure of this sequence, with reference to similarities across all the cases. Section 3 will discuss how the doctor's question design and patient's normalising answering turn create the context in which these corrections appear. Question and answer sequences in clinical interactions have been largely studied in Conversation analysis (Heritage & Robinson, 2006b;. Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007; Heritage & Sorjonen, 1994; Maynard & Heritage, 2005; Stivers & Heritage, 2001) but also relevant is the wider literature on how the grammatical design of a question makes a particular answer relevant and even preferred (G. Raymond, 2003).

Section 4 focuses more directly on the corrections themselves, on their variation in design and what projects they might be managing, through upgrading, within the context of the wider clinical interaction.

2 The pattern in which the companion corrects the patient's answer.

I have observed a recurrent pattern in which the companion corrects the patient's version in their preceding answer. The correction systematically upgrades the account offered by the patient. An example is the following:

<u>Extract 1 [167: Spouse: 17.27] (Back pain.)</u>

```
Pat:   [cause  I know]
Doc:   [you   told  m]:e you had u:m a
       hysterectomy and Asthma=any other
       health problems, recently?
            (0.3)
Pat:   °(No,)°
             (0.9)
```

```
08  -->  Com:   Back  pain.
```

This segment is part of a series of history taking questions made by the doctor. At line 01 the doctor enquires about other health problems, using the construction “any other health problems, recently.” and is given a ‘no symptom’ answer from the patient (“no”) at line 07. The companion corrects the patient’s response by mentioning “back pain” as being a health problem the patient is experiencing. This correction upgrades the patient’s no symptom answer to a symptom answer (back pain).

This pattern; an upgrading correction from the companion following the patient answering the doctors question, can be observed in the following examples as well.

Extract 2 [177: Care worker: 25.13] (Eye sight)

```
01      Doc:   Mm. So apart from thi:s <schizophrenia> have
02             you had any health problems.
03             (0.6)
04      Pat:   Any health problems?
05             (3.3)
06      Pat:   No:
07             (1.5)
08      Pat:   <no no> physically:
09             (0.3)
10 --> Com:    Your e:ye sight’s deteriorating a lot
11             [in’t it?]
12      Pat:   [Yeah   y]eah
```

Extract 3 [173: Parent: 10.15] (Low Blood Pressure)

```
01      Doc:    So other than the attacks how have you been
02              in the past=have you had any other health
03              problems,
04              (0.9)
05      Pat:    No[t  anymore,  ] ((gaze to com))
06 --> Com:       [I think she s]uffers with low blood
07              pressure don’t you?
08              C[os when s]he’s been to her GP
09      Pat:     [ (    )  ]
10              they’ve noticed it’s lo:w.
```

Both extract 2 and 3 are similar to extract 1 in that the doctor asks a similar question with a similar question design (“any (other) health problems”) and in each case receives a ‘no symptom’ answer. The companion in each case corrects this by offering a symptom (line 10 in extract 2 (eye sight is deteriorating), and line 06 in extract 3 (low blood pressure)).

In the previous cases doctor and patient turns have all been strikingly similar; nevertheless the pattern of upgrading corrections still holds in cases where the doctor has

asked a question with an open question design, or when the patient's answer does refer to or describe some adverse symptom they have experienced. This can be observed in the following extract which occurs early on in the consultation during problem presentation. The doctor has asked about the number of times they have been to hospital due to attacks, and both patient and companion have indicated that it has been frequent (with the companion specifically mentioning A&E). The doctor asks more specifically about how many times they have been to A&E.

Extract 4 [162: Spouse: 13.52] (Times in A and E)

```
01  1--> Doc:  So how often have you been to A and E?
02             (0.2)
03  2--> Pat:  U:m (0.2) I think I've been admitted three times.
04             Four times.
05             (1.0)
06  2--> Pat:  U:m ma:rch ((starts counting on fingers))
07  3--> Com:  Na:h A and E's more frequent than that.
```

The patient's answer at line 03-06 is corrected by the companion at line 07, starting with the correction marker "Na:h" before both an embedded correction of "admitted" to "A&E" and an exposed correction (Jefferson, 1987) of "more frequent than that". The significance of A&E visits, as opposed to "admittance," is that A&E would not result in stays in the hospital and would be more frequent.

In extract 5 the doctor is asking whether the medication the patient is taking is effective. The patient confirms and then as evidence adds that he no longer gets shakes.

Extract 5 [155: Spouse: 6.22] (The Shakes)

```
01 1--> Doc:    .hh And since the change in medica:tion
02              (0.4) it's got better=do you think?
03 2--> Pat:     Yeah,
04              (0.8)
05 2--> Pat:    Defin (.) eh I I don't get the shakes
06              now.
07 3--> Com:    As mu:[ ch.]
```

Extract 5 shows the same pattern of correction where the patient's account is downgrading the symptomatic severity. Here the downplay is used as evidence to show that the medication has worked by saying a symptom is now gone (line 05); the companion corrects this account through the use of an increment "As much" at line 07. This adjusts the patient's answer from "I don't get the shakes now" to "I don't get the shakes now, as much". Making this

adjustment upgrades the symptomatic severity of the answer by suggesting that while improved, the shakes are still present.

Corrections can also be designed to be directly contradictory to the patients turn, as in extract 6).

Extract 6 [178: Spouse: 14.50] (Stress)

```
01 1--> Doc:   =.hh I wonder what (0.3) a- you know (0.3) whether
02             stress has a_
03             (1.0)
04 2--> Pat:   [We:ll I'm,] I'm not really stressed am I:?
05      Doc:   [(        )]
06 3--> Com:   I don't kno:w=I think you- I think you are stressed
07             I thi[nk you ]
08      Pat:        [ With   ]Work li:ke.
09      Com:    Yea:h I think
```

The patient's answer at line 04 resists the doctor's question asking about stress, downplaying the problem by saying "I am not really stressed" He glances at the companion while asking "Am I?" in this case, a contribution from the companion is invited. The companion's turn corrects the patients "I'm not really stressed" with "I think you are stressed". This correction is mitigated with epistemic markers, but nevertheless upgrades the symptom from "not really stressed", to "stressed"

The overall pattern of these corrections falls into a three-stage sequence.

Stage 1: The doctor asks a diagnostic question

Stage 2: The patient answers with a 'no symptom' report or downplaying symptomatic severity

Stage 3: The companion corrects the patient's answer, upgrading the symptomatic severity

These instances occur mainly within the problem presentation and history taking phases of the consultation. The questions asked by the doctor in the first stage are diagnostically relevant, though the design and valence of their questions may vary. For example questions 1-3 are all negatively polarised "any health problem" questions. This is different from extract 5 that is designed for a "yes" answer. In extract 6 the question is an open "WH" question and has no

polarisation, and is designed to ask about something that may be delicate or problematic (bringing up stress).

The second stage of the sequence is the patient's answer. Like the questions, and in some cases because of the question design, there is some variety in form. There are some similarities over all of the extracts where the patient's answer is either a no symptom or down plays the severity of the symptom. Extract 4 is an example of the later, it does not give a no-symptom answer (like in the other extracts) but does down play the symptomatic severity of her symptoms . Her account at lines 03-04 minimizes the frequency by choosing to answer how many times she was admitted, which would be a smaller amount than how many times she has been to A&E.

Stage 3 of this pattern is the correction itself, which consistently upgrades the patient's answer. This correction can be done in a variety of ways, either by suggesting symptoms when there were none (examples 1-3), increasing the frequency (ex.4), or adjusting the answer as in extract 5 from "none" to "not as much", or directly contrasting the patient's answer, e.g. extract 6) "not really stressed" to "you are stressed".

3 Question and answers

The first two steps in the 3-part sequence of companion corrections involve the doctor asking a question and the patient responding. These two steps provide the context in which the companion corrects the patient's response. This section examines the distinctive features of the question and answer turns in the context of this pattern. Namely that the doctor's question is important to diagnosis and/or treatment, and the patient's turn gives an answer which downplays or minimises their condition in some way. This can be observed in the following example;

Extract 7 (from ext. 1) [167: Spouse: 17.27] (Back pain.)

```
01     Pat:    [cause  I know]
02 -->Doc:    [you   told  m]:e you had u:m a
03            hysterectomy and Asthma=any other
04            health problems, recently?
05            (0.3)
06 -->Pat:    °(No,)°
```

In extract 7 the doctor's question at lines 02-04 is asked in the course of history taking, and is exploring symptoms or other health problems which may or may not be related to the patient's attacks. It is designed with an "any" format, so designed grammatically as

negatively polarized to prefer a “no” answer from the patient (G. Raymond, 2003). The question design is also designed to minimise a symptom answer in other ways; the doctor pre-empts some of the health concerns he does know about, meaning that he is asking about any other health concerns or symptoms. He also restricts the parameters of the question to recent symptoms.

The patient answers according to the preference of the question, with a quiet “no” at line 06. This answer does not provide any new symptoms, and is therefore a “no symptom”/minimising symptom answer.

Extract 8 (from ext. 4) [162: Spouse: 13.52] (Times in A and E)

```
01     Doc:  So how often have you been to hospita:l?
02           0.4)
03     ( ):  tch
04     Com   H[H]
05     Pat:  [f]hhh probabl=Well in the last six mo[nth]s?=
06     ( ):                                        [hh ]
07     Pat:  =the [las]t ye(h)a:r .h[h   [u:m ]
08     Doc:       [mm ]
09     Com:                          [ A a[nd E]:=
10     Doc:   =Mm:.
11     Pat:   >I don’t know<=cos a lot of times I I won’t stay
12            anyway=I just discharge m[yse]lf,
13     Doc:                            [mm ]
14 -->Doc:    So how often have you been to A and E?
15            (0.2)
16 -->Pat:    U:m (0.2) I think I’ve been admitted three times. four
17            times.
18            (1.0)
19     Pat:   U:m ma:rch
20            (0.4)
21     Com:   Na:h A and E’s more frequent than that.
22            (0.2)
23     Com:   pr[obably.]
24     Pat:     [Yeah  I]’m on about sta:ys in
25            hospital=[times a week]
26     Doc:            [Ten times in] A and E? ((gaze to Com))
27     Pat:   I [DOn’t even think it’s tha:t.]
28     Com:     [I    would    sa:::y   betwe]en about eight and
29            ten=something like that=to actually get to A & E: via
30            ambulance=y[es.]
31     Doc:              [mm ]
32     Pat:   It’s not that m[any.]
33     Com:                  [ Ye:]ah it is
34            (1.8)
35     Com:   And b- (0.4) half of tho:se you’ve probably (0.8)
36            either been >discharged or discharged yourself<=the
37            other ha[lf you’ve eithe-]
38     Doc:           [And what do y-  ] What er treatments have you
39            h:ad?
```

Extract 8 occurs at the beginning of the consultation; the question on line 14 is aimed at finding out the frequency of her attacks, and how often they have ended up in A&E because of them. The turn-initial 'so' indicates that it is part of a larger sequence of questioning and comes directly from previous talk. This extract is different from the previous one in both how the question is asked and the format of the answer; the doctor's question is an open question, rather than designed for a polarised answer.

The patient's answer on line 16 gives an estimate of the frequency of the symptoms, but plays down their severity by choosing to answer times admitted rather than times in A&E, which would naturally be a smaller number, as admittance means overnight. This demonstrates how the patient's turn can be downplaying independently of the doctor's question design.

In all these cases, the doctor's question seeks information related to the patient's condition, its diagnosis and possibly treatment. They are related to the experience of the patient of the severity of their health concern, and in some cases, the frequency and amount of medication they are using to deal with a symptom. They are all focused on aspects that are related to figuring out what the diagnosis is and/or the impact of the condition on the patient. However, the varying grammatical formats of these questions and their valence are designed for a socially positive or negative (minimising severity or upgrading).

Extract 8 is an example of how the minimising of symptoms in the patient's turn is not always contingent on the grammatical format or valence of the doctor's question. More relevant is the fact that the doctor's turn is seeking symptomatic or diagnostic detail; when these upgrading corrections occur, the patient has minimised or given a "no problem" answer.

In some cases the question design may be part of what is shaping patients answer to be minimising or a no answer. The way the question turn is designed both grammatically and valence has sequential consequences for how the answer is formed (G. Raymond, 2003; Sacks, 1972). This can even be seen in cases where the patient's turn is pushing against the valence or polarity of the doctor's question, in how the answer is more elaborated, then when it is aligning.

However, the most common question-answer sequences that preceded upgrading corrections are "any" formulated questions followed by a "no" answer. In these, the patient's and doctor's turns align grammatically and in their valence. Questions designed with an "any" format were relatively common, preceding an upgraded correction. This may be due to the negative polarisation of the question creating an environment in which the patient answers with a no symptom answer even if they have one or some.

This is supported by previous research that found that a patient is far more likely to produce a “no” answer to a doctor asking about additional health concerns if the doctor’s question design has “any” in it, even if the patient has additional concerns. This is due to the way an “any” question is designed to prefer a “no” answer (Heritage, et al. 2007) In my collection, in 8 out of the 20 cases, the doctor’s question is designed with an “any” formulation, in all of these cases the patient’s response is a no, (or a strong negative answer).

Extract 9 (from ext. 2) [177: Care worker: 25.13] (Eye sight)

```
01-->Doc:   Mm. So apart from thi:s <schizophrenia> have you had any
02          health problems.
03          (0.6)
04-->Pat:   Any health problems?
05          (3.3)
06   Pat:   No:
07          (1.5)
08   Pat:   <no no> physically:
09          (0.3)
10   Com:   Your e:ye sight’s deteriorating a lot [in’t it?]
11   Pat:                                         [ Yeah  y]eah
```

Extract 10 (from ext. 3) [173: Parent: 10.15] (Low Blood Pressure)

```
01-->Doc:    So other than the attacks how have you been
02           in the past=have you had any other health
03           problems,
04           (0.9)
05-->Pat:    No[t  anymore,  ]
06   Com:      [I think she s]uffers with low blood
07           pressure don’t you?
08           C[os when s]he’s been to her GP
09   Pat:     [ (    )  ]
```

Both extracts 9 and 10 have similar doctor’s questions and answer formats to extract 1. “have you had any (other) health problems?” They differ slightly from extract 1 as instead of a straight “no” in both cases the patient’s push back a little against the contingency of the doctors question design for a “no” answer.

Extract 9 does this by, after answering with the preferred “no” on line 06, adding “physically” on line 08 which suggests while there are not any health problems physically there might be other non-physical health problems (like his schizophrenia). Extract 10 pushes back a little by saying “not anymore, rather than “no”, while still negatively valanced her answer incorporates “anymore” which implies there were other health problems in the past. While both cases push back against the preference for a “no” answer, they are both still either no symptom, or minimising symptom answers.

Extract 11 [184: Spouse: 03.40] (Family History)

```
01 --> Doc:     Family history of any epilepsy?
02              (0.8)
03 --> Pat:      No,
04     Com:      Didn't you- (0.2) mum sa:y that your granddad=I
05               think (0.8) think your dad's dad had it?
06              (1.6)   ((Doc looks at Pat))
07    Pat:      °Epilepsy° ( o[h    )]
08    Com:                    [Ye    ]ah
09    Pat:       ye[a:h buet-]
```

The doctor's question on line 01 though not a symptom, provides information relevant for diagnosis. It is designed, with an "any" format for a "no" answer, and this is what he receives at line 03, a "no".This no answer is not downgrading symptiomatic severity but is "no" answer to a detail that is understood to be diagnostically important, to which the companion orientates as in need of correction. This suggests that the doctor's questioning is symptomatic or diagnostic should be understood as an approximate description for how the question is targetting details that are relevant for diagnosis, and understanding their severity and impact on the patient

Similarly, history-taking questions about medication may be related to other possible symptoms and health conditions, but are not themselves diagnostic.

Extract 12 [064: Spouse: 21.18] (Headaches 1)

```
01 -->  Doc:     And do you take any tablets at a:ll?
02 -->  Pat:     No: on the contraception pill °that's it°
03      Com:     na- ah wa Be truthfu:ll. What do you take
04               all ti:m[e?]
05      Pat:             [ O]h Ibuprofe:n f[or ah] m migrai:ne.
06      ( ):                               { sh  ]
07      Doc:     hmm mm so you've got a problem with headache.
08             (0.4)
```

While not itself diagnostic this question (line 1) and the subsequent talk opens up discussion about migraines, which is a symptomatic issue. The polarity of the doctor's question favours a 'no' answer, and like in previous extracts (9 and 10) in this extract the patient first answers in a way which aligns with the polarity of the question, before expanding her answer with a pill she is on. The patient's answer minimises how much medication she takes with "that's it.".

As stated before, the doctor's question design can vary. In some cases, it can be polarised for a yes answer. In the following extract, the answer is polarised for a yes, but is

similar to the previous examples because the question is positively valence/optimised (i.e. designed to seek the most socially positive answer).

Extract 13 (from ext. 5) [155: Spouse: 6.22] (The Shakes)

```
01  --> Doc:  .hh And since the change in medica:tion
02            (0.4) it's got better=do you think?
03  --> Pat:  Yeah,
04            (0.8)
05  --> Pat:  Defin (.) eh I I don't get the shakes
06            now.
07      Com:  As mu:[ ch.]
```

The difference between this and previous examples is that the polarity of the question is preferenced for a yes answer. However, here the question is seeking an answer where the "yes" is the optimal answer, meaning that the valence is similar to extracts 7, 9,10,11 and 12 because it is seeking an answer which is understood as optimal (that the medication is working). This means that, while its polarity favours a 'yes', it is still polarised for an answer, projecting less symptoms rather than more.

This question is both related to treatment, symptoms and diagnosis. If the medication is working then the diagnosis is more certain. The question is designed with an and-preface, attaching this to a sequence of questions before it (Heritage & Sorjonen, 1994); it is formed as a statement with a tag question "do you think?" latched on the end of it. This design takes quite a strong grammatical stance that the answer to this is 'yes'. The patient confirms on line 03, with evidence that it is better. Line 05 provides a "no symptom" account for his answer.

In all these cases, the patient's answer has mostly been in alignment with the polarity and preference of the question design, with only some slight pushback in a few cases. In the next example the answer to the question works against the grammatical and valence preference of the question.

Extract 14 [179: Spouse: 2.44] (Anxiety)

```
01    Pat:    The °only° thing since the first incident ter I have
02            lost my memory.
03            (0.4)
04    Pat:    Memo[ry's qui]te shocking.
05    Doc:        [ Y e : s]
06    Doc:    ye:s.
07            (0.6)
08    Doc:    .hh I'm afraid that seizures do upset memory=or
09            can upset mem[ory.]
10    Pat:                 [ Mm ] hmm.
11            (1.5)
12--> Doc:    U:m are you getting anxious about it?
```

```
13            (0.4)
14--> Pat:    Not particularly anxious but Te(h)r
15-->           [J[ust   er  con]cern [me a ]little Bit]
16    Doc     [ [(                        )]
17    Com     [He's not sleep]        [   h e 's  n o t] sleeping.
18    Doc:    Not sleeping=[so h]e h[es?
```

This extract is distinctive in several ways. The first is that the doctor's turn is not diagnostic questioning. Here he is discussing a symptom the patient is having and is gauging the impact of this symptom (whether it is causing the patient anxiety). In the second, unlike previous the cases, this question is not optimised for a socially desired answer, but instead is designed to project that the patient is anxious about his memory loss. This means that while in previous cases a "no symptom" or minimised condition answer is more congruent, in this case it is in disagreement with the presuppositions in the doctor's question.

The patient's answer here displays that disagreement in several ways; rather than a straight "no", the turn is more elaborated. "Not particularly anxious but Te(h)r Just er concern me a little Bit". on lines 14-15. The patient's answer pushes back against the idea of anxiety and downgrades it to "concern". This is further downgraded with "Just" and "a little bit". The patient's downplaying of his worry about the memory loss minimalizes the impact that symptom is having on him, and this is what the companion orientates to in her correction.

Another way that a patient can downgrade their answer to a positively polarised question is to make it conditional as seen in the extract below. The following extract occurs a little bit after extract 12. It has been established that the patient frequently gets migraines and takes, according to the companion, an excessive amount of Ibuprofen.

Extract 15 [064: Spouse: 21.18] (Headaches 2)

```
53    Doc:     And how often do yo:u have to lie do:wn and=or how
54             often do you vomit?=how often does it get that ba:d,
55             (0.8)
55    Pat:     Couple of ti:mes (0.2) a week.
56             (8.0)
57    Doc:     And on th the rest of the da:ys?
58             (3.0)
59    Pat:     >I can get< U:::m (0.2) bits of headaches but it's not
60             as bad as the actual mi:gr[ai:]ne itself.
61    Doc:                               [mm ]
62             (0.4)
63--> Doc:     But you take Ibuprofen every day?
64             (1.2)
65--> Pat:     If I get a headache yes
66              (0.8)
67    Com:     No sh[e takes a-}
68    Pat:          [ It's  the] only thing=
69              tha[t   (     )    that   gets] rid of it
70    Com:         [She tAkes them E:very day.]
```

The doctor's question on line 63 is designed as a declarative and rising intonation. This is a very assertive design built to prefer a 'yes' answer. It is followed by a long pause at line 64, which is some indication of the dis-preference of the patient's turn to come.

In the patient's turn at line 65 the patient pushes back against the presupposition of 'every day' with the conditional "if I get a headache" before answering yes. The order of the conditional and confirmation are important; placing the conditional before answering with a type conforming answer goes against congruity and gives the conditional primacy over her yes answer. While she has confirmed she takes Ibuprofen frequently, she has downgraded the extreme case formulation "every day" by making it contingent on her headaches. This also places taking pain medication in the context of the symptom rather than something she does every day, making taking pain medication a more "reasonable" thing for her to do.

In cases where the doctor's questions are designed for a negatively valenced answer, but the patient's answer is positively valenced, and minimising, the patient's answer is often not type conforming. This is consistent with Sacks's observations on agreement and congruity (Sacks 1986).

<u>Extract 16 [162: Spouse: 15.39] (Bladder control)</u>

```
01   Doc:    Have you bit your tongue befo:re in these attacks?
02   Pat:    Yeah I have bit my tongue before.
03          (1.6)
04-->Doc:    And do you lose control of your bladder in the attacks?
05-->Pat:    I have done
06          (0.7)
07-->Pat:    I think maybe once or twi:[ce.
08   Com:                              [Yeah=I >(would/was going to)
09          say three or four times< but (.) very infrequently.
```

In Extract 16 the doctor's question at line 04 is and-prefaced (Heritage & Sorjonen, 1994) designing it as to be linked to the previous line of questioning. The design of the question is not optimised (Heritage & Robinson, 2006), which is similar to extracts 8 and 9. The patient's answer is marked - instead of answering with a type-conforming "yes" she answers "I have done". The design of her answer, specifically the tense downgrades the affirming nature from a "yes". It downgrades by restricting the tense of the affirmation to one or some instances in the past rather than something that she does possibly every time. This is further downplayed after a pause, where she explicitly restricts the instances to "maybe once or twice". Though the "I think" and "maybe" mitigate her certainty on the number of times.

In the following extract the doctor, begins to suggest that stress may have a role in the attacks.

Extract 17 (from ext. 7) [178: Spouse: 14.50] (Stress)

```
01-->Doc:   =.hh I wonder what (0.3) a- you know (0.3) whether
02          stress has a_
03          (1.0)
04-->Pat:   [We:ll I'm,] I'm not really stressed am I:?
05   Doc:   [(        )]
06   Com:   I don't kno:w=I think you- I think you are stressed
07          I thi[nk you ]
08   Pat:        [ With   ]Work li:ke.
```

In extract 17 the doctor's question design has a low epistemic stance, and is not very assertive; along with the self-repair, the question is mitigated with "I wonder" "whether" and ends by trailing off. The patient's answer on line 04 both pushes back against it. The answer is well prefaced, and minimises the idea of stress, with "not really". This is followed by a tag question directed at the companion.

The patient's minimising answers do not only occur when the doctor's question is polarised for a 'yes' or 'no' answer. There has already been an example of this in extract 4, where the doctor asked an open-ended question about the frequency of visits to A&E. When the question design is open, the design of the question further influences the form of the answer; patients' turns can be minimising independent of the question. In the following examples the doctor is asking an open question.

Extract 18 [162: Spouse: 00.58] (Attacks per week)

```
03   Pat:   °Mm(0.4)I'm having sei:zures
04   Doc:   Mm hmm,
05   Pat:   Which ar:e quite uncontrollable at the moment,
06   Doc:   Mmmm.
07          (0.6)
08   Pat:   U:m
09          (0.2)
10   Com:   Weekly
11   Pat:   Ye(h)ah (°weekly  °)
12          (4.8)
13-->Doc:   On:e a week, or more than that
14         (0.6)
15-->Pat:   U:m say one a week
16         (0.4)
17   Doc:   Several a week
18-->Pat:   O:ne a week
19   Doc:   Mm hmm
20   Com:   Sometimes it can be a couple sometimes she can go about
21          ten da:ys but I think ten days is about the mo:s[t:
22   Doc:                                                   [mm] hmm
```

The question at line 13 asks for clarification about what “weekly” means. It is designed as an “or” question, and gives two options; “one a week” or “more than one a week”. This line of questioning, like extract 4, is enquiring into the impact/severity of the attacks as a symptom, by enquiring how many times a week they occur.

This example is slightly extended due the repair insertion on line 17-18. After the patient’s first answer at line 15, the doctor initiates repair, interestingly by given a higher frequency answer, but the patient continues to pick the minimal amount of time a week the attacks could happen (line 18).

Extract 20 [076: Spouse: 14.33] (Amount of medication)

```
01     Doc:   u:m are you >on any tablets<=at all?
02     Pat:   No.
03            (0.2)
04     Pat:   just (0.5) Ibrofen and u::m,
05            (0.6)
06     Com:   °Paracetamol.°
07     Pat:   >Yeah °Paracetamo[l°.
08     Doc:                    [How #many of those do you take on
09            average¿#
10            (0.7)
11     Pat:   I ta:ke one Bru:fen and a Paracetamol.
12            (1.8)
13     Pat:   when it sta:rts.=but sometimes it’s really bad=I take
14            two Brufen (.) and a Paracetamol [and that’s.
15--> Doc:                                     [So on average per day
16            how many Ibuprofen?
17--> Pat:    I have ‘em for probably three times a day but
18            sometimes [I just don’t touch it.
19     Com:             [It just depends he’s having it four times a
20            day
21     Pat:   ((     ))
22     Com    it just depends on how the headaches are.
23     Doc:    So you the the your doctor mentions Zopiclone
24             Omeprazole are you still taking those or?
```

Extract 20 is part of a bigger sequence where the doctor is pursuing how many pain killers the patient takes on average. The correction occurs after the doctor has asks specifically for the amount per day and the patient answers at lines 15-17. The doctor’s question at lines 15-16 is so-prefaced, indicating that it is in relation to the previous answer in which the patient describes the dose he takes when he takes pain killers – which suggests that the patient’s previous question wasn’t sufficient. The patient’s answer pushes back by not answering how many, but rather how many times he takes a dose, leaving ambiguous which dose he is taking, then minimises it further with “but sometimes I just don’t touch it”.

As demonstrated by these examples minimising or a ‘no problem’ answer is the most consistent aspect of the pattern. They are all in some way either giving a no problem answer or are minimising. In their corrections, companions provide information that resists or works against the ways in which patients minimise their symptoms.

These questions tend to be asked during history taking and problem presentation, and are concerned with symptoms, the impact of symptoms and diagnosis. While contiguity and question design can and do play a role in the formulation of the patient’s answer, the patient’s answer can also be pushing back against the doctor’s formulation, in order to be minimizing. When the doctor’s question is open ended, it has tended to be part of a longer sequence of questions where the patient’s previous answer has been insufficient. This can be seen in extracts 20, and 19. For example in extract 19 the doctor is clarifying what the patient meant by weekly, and in extract 20, the doctor has asked how many the patient has taken on average, and clarifies how many the patient takes on average *per day* after the patient answers with how many they take when it starts. “ I ta:ke one Bru:fen and a Paracetamol. when it sta:rts.=but sometimes it’s really bad=I take two Brufen (.) and a Paracetamol”.

4 Upgrading corrections.

The focus of this section is the companion’s correcting turn in the sequence. The companion’s turn corrects the patient’s minimising response in the sense that the companion changes or amends factual details about the information provided by the patient.

In these cases, the companion uses the mechanisms of correction to offer an alternative version to the patient’s answer. In all cases the corrections come after an instance where the patient’s answer is minimising in some way. This minimisation is the part of what the companion is correcting, as they use the correction mechanism to upgrade the severity of the problem presentation in their turn, slightly, pushing back against the patient’s minimisation.

<u>Extract 21 (from ext. 1 and 7) [167: Spouse: 17.27] (Back pain.)</u>

```
01     Pat:    [cause  I know]
02     Doc:    [you   told  m]:e you had u:m a
03             hysterectomy and Asthma=any other
04             health problems, recently?
05             (0.3)
06 -->Pat:     °(No,)°
07             (0.9)
08 -->Com:     B[ack ] pain.
09     Pat:     [(  )]
10     Pat:    .h N- I damaged me back
```

```
11            [as ch]i:ld= so.
12    Doc:    [  Mm.]
```

In extract 21, the patient answers at line 06, “no” which is a “no problem” answer to the doctor’s question “any other health problems”. The companion corrects this at line 08. It is a correction because by offering the detail “back pain” the companion is changing the ‘no’ answer, by suggesting there are other health problems. The formulation of the correction is interesting as it consists of just suggesting a possible symptom. It does not need an explanation to be understood as offering a different answer.

Overall the common feature of these corrections is that they are correcting instances where the patient’s answer is a “no problem” or minimising answer, so that the correction is not just changing a factual detail but corrects the patient’s downplaying by upgrading it. The companion orientates to the minimising as part of what needs correcting. In the following cases the companion’s turn corrects the patient’s answer, pushing back against the patient’s minimisation with a correction that offers an upgraded version. They involve a movement from no problem/minimised problem patient responses to a problem or increased severity of the problem. In extract 21, the upgrading movement is from a “no health problem” answer to an answer where the patient also has back pain. In the following example, the correction is from a minimised estimate of frequency to a larger estimate.

Extract 22 (from ext. 16) [162: Spouse: 15.39] (Bladder control)

```
01  Doc:    Have you bit your tongue befo:re in these attacks?
02  Pat:    Yeah I have bit my tongue before.
03          (1.6)
04  Doc:    And do you lose control of your bladder in the attacks?
05  Pat:    I have done
06          (0.7)
07->Pat:    I think maybe once or twi:[ce.
08->Com:                              [Yeah=I >(would/was going to)
09          say three or four times< but (.) very infrequently.
10          (1.3)
11  Com:    Also=actually when she comes rou:nd from the:se=her
12          e:yes °have° usually (.) >°sort of°< conve:rging and she
13           can’ t focus.
14  Doc:    [ M m : : .]
15  Pat:    [(Yeah) the] vision completely goe:s.
```

The second part of the patient’s response here, “ I think maybe once or twice,” (line 7) clearly minimises the problem of her bladder control - the companion’s correcting response to which is to upgrade the problem, “ I (would/was going to) say three or four times. This offers an alternative version of the estimated frequency of loss of bladder control, though in a turn that

is designed not to be overtly challenging or corrective, but instead more collaborative. By first agreeing with the patient (yeah) and marking it as his estimation with "I was going to say", which highlights that his answer would be slightly different but not dismissing the patient's version; he then concludes with "but very infrequently" which sum's up his answer in a way that aligns both his version and hers, as being both indicating that loss of bladder control is infrequent. Therefore, he is aligning with the gist of the idea that it happens infrequently. This matter of achieving alignment between companion and patient is common in this type of correction.

While the corrections are all focused on correcting the minimisation in the patient's turn, they vary slightly in form. This can already be seen in examples 21 and 22. How they design their turn is influenced by how the patient's answer is formulated and their epistemic rights to make the correction. The form of the turn can also characterise the patient's answer in some way,; for instance it can be designed to be collaborative, or instead to be more challenging. In cases like extract 21, this involves moving from a "no problem" version to a "problem" version, as in the following cases.

Extract 23 (from ext. 10 and 3) [173: Parent: 10.15] (Low Blood Pressure)

```
01  Doc:    So other than the attacks how have you been
02          in the past=have you had any other health
03          problems,
04          (0.9)
05->Pat:    No[t  anymore,  ]
06->Com:      [I think she s]uffers with low blood pressure
07          don't you? C[os when s]he's been to her GP
08  Pat                 [ (    )  ]
09          they've noticed it's lo:w.
10  Doc:    Mm hmm.
11          (0.8)
12  Doc:    So do you get dizzy when you stand up quickly?
13          (0.5)
14  Pat:    °No.°
15          (1.8)
16  Doc:    .hh Um
17  Pat:     =Cos they only: checked me blood pressure >cos
18          I was a new patient< with new doctor[s.
19  Doc                                         [Mm.
20  Pat:    A[ : : n  d  ]
21  Com:     [you have ha]d it (    [   ).]
22  Pat:                            [bit Y]eah (0.4)
23          but they just ((   )) which I didn't even know
24          I had.
25  Doc:    So what are all these othe:r notes about you?
26          (0.5)
27  Pat     Iu:m (2.0) I used to °have° >tummy ache=but
28          basically< that's righted itself now.
29  Doc:    So where did you have tummy aches?
30  Pat:    Just (0.4) above (.) just under me rib ca:ge?
```

```
31  Doc:    How old were you.
```

Extract 24 (from ext. 2 and 9) [177: Care worker: 25.13] (Eye sight)

```
01  Doc:   Mm. So apart from thi:s <schizophrenia> have you had any
02         health problems.
03         (0.6)
04  Pat:   Any health problems?
05         (3.3)
06->Pat:   No:
07         (1.5)
08->Pat:   <no no> physically:
09         (0.3)
10->Com:   Your e:ye sight's deteriorating a lot [in't it?]
11  Pat:                                        [ Yeah  y]eah
12         (0.3)
13  Pat:   Apart fr[om that though.]
14  Com:           [(              ]          ).
15  Pat:   Mm.
```

In both extracts 23 and 24 the patient gives a "no problem" (line 05, extract 23 and line 06-08, extract 24) answer to the doctor's question of "any other health problems". In both cases, the answer pushes back a little at the assumptions of the question, redefining what is relevant to discount their symptoms from a yes answer. In extract 23 the question asked about any other health problems in the past, the patient pushes back by answering "not anymore" suggesting there were problems in the past but they are not relevant now. In Extract 24 the patient answers that there are no *physical* health problems, "no no physically", indicating there are non-physical (mental health) problems but the patient discounts them from the parameters of the question, accounting for the no answer. In both cases the companion corrects the patient's answer by suggesting a symptom.

In extract 23 this is addressed to the doctor at first, "I think she suffers from low blood pressure" before being addressed to the patient through the tag question "don't you." This is followed by an account, again referring to the patient in third person, as the inclusion of this new health problem. The correction is formulated with epistemic markers, e.g. "I think". The companion orients to the fact that she has less epistemic right to this knowledge about the patient's health than the patient himself, and therefore does more work to justify her answer, with the use of the tag question to seek confirmation from the patient. In extract 24 the companion also uses a tag question in the formulation of their correction. "your eye sight is deteriorating a lot, isn't it," which is immediately confirmed at line 11 by the companion, in overlap with the tag question.

When contrasted with extract 21, where the suggested symptom "back pain" is enough on its own to offer a version of the answer that corrects a "no problem" version (the patient's)

to a “problem” version (the companion’s). The companion’s correction in extract 21 appears to take a stronger epistemic stance, as it does not seek confirmation.

In both extract 23 and 24 the problem that is being corrected is a version that contrasts with their no-problem claim. In extract 24 the patient’s “not physically” is corrected by the suggestion of a physical ailment, eyesight; whilst in extract 23 the companion formulates her suggested symptom using a present tense, contrasting with the patient’s answer of “not recently” as it not only suggests recently but that this is an ongoing state.

In extracts 25 and 26 the patients’ answers are full statements, rather than a “no” as in previous examples, to yes/no interrogative.

Extract 25 (from ext. 5 and 13) [155: Spouse: 6.22] (The Shakes)

```
01   Doc:    .hh And since the change in medica:tion
02           (0.4) it's got better=do you think?
03   Pat:     Yeah,
04            (0.8)
05   Pat:     Defin (.) eh I I don't get the shakes now.
06   Com:     As mu:[ ch.]
07   Pat:           [I d-] I I just (1.1) trip a bit
09            (and then I [get./ now and a[gain)
10   Com:                 [you se]em to [be un]steady,
11  (Doc):                             [ye:s ]
12   Pat:     a bit unsteady on my feet=that's all.
```

Extract 26 [077: Friend: 6.53] (Sleepy)

```
01    Doc:  So you Went on Keppra, (0.7) At two-fifty twice a
02          da:y (0.7) and felt drunk. (2.0) You're no:w on just two-
03          fifty milligra:ms dai:ly. And is that making you sleepy?
04          (0.8)
05    Com: I g[ive him them at ni:ght-ti:me.]
06    Pat:     [I   c a n -  I   c a n   slee]p all right=don't I?
07          (0.8)
08    Com: Someti(h)mes.
09          (1.2)
10    Doc:  But probably it's not- But you've had a recent attack
11          >haven't you?< So it's probably not doing enough really.
12    Pat:  (No.)
```

In both extracts 25 and 26, the statement, given by the patient is a “no problem” or minimising statement. In extract 25, this is at line 05 “Defin. eh, I I don’t get the shakes now.”, in extract 26 this is at line 06. “I can sleep all right, don’t I?”. The tag question “don’t I” invites confirmation from the companion. In each case the companion adjusts the patient’s answer using an increment in extract 25, this is at line 06. The “as much” counteracts the patient’s minimising, by adjusting “don’t get shakes” to “don’t get shakes as much.” This is

upgrading the problem presentation by adjusting the patient's claim of not getting shakes, to not getting shakes *as much*, suggesting they do sometimes still get the shakes.

The companion's turn in extract 26 does something similar, adjusting "I can sleep all right" to "I can sleep all right sometimes," upgrading the problem by suggesting that sometimes the patient does not sleep well (or indeed that he sleeps 'all right' only sometimes).

In the cases where the patient's answer estimates a number, one interesting finding is that the companion's correction provides a slightly higher number. This has already been observed in example 22, where the patient estimates "once or twice" and the companion corrects that to "I was going to say three or four times." A similar pattern occurs in the following two examples.

Extract 27 (from ext. 18) [162: Spouse: 00.58] (Attacks per week)

```
01  Doc:   How can I help,
02         (0.4)
03  Pat:   °Mm(0.4)I'm having sei:zures.
04  Doc:   Mm hmm,
05  Pat:   Which ar:e quite controllable at the moment,
06  Doc:   Mmmm?
07         (0.6)
08  Pat:   U:m.
09         (0.2)
10  Com:   Weekly.
11  Pat:   Ye(h)ah (°weekly  °)
12         (4.8)
13  Doc:   On:e a week, or more than that?
14         (0.6)
15->Pat:   U:m say one a week,
16         (0.4)
17  Doc:   Several a week,
18->Pat:   O:ne a week.
19  Doc:   Mm hmm
20->Com:   Sometimes it can be a couple. Sometimes she can go about
21         ten da:ys but i think ten days is about the mo:s[t:
22  Doc:                                                   [mm] hmm.
23         (0.4)
24  Com:   distance between them.
25         (1.0)
26  Doc:   So these- (.) when when when was your last seizure?
```

Extract 28 (from ext. 20) [076: Spouse: 14.33] (Amount of medication)

```
01    Doc:   u:m are you >on any tablets<=at all?
02    Pat:   No.
03           (0.2)
04    Pat:   just (0.5) Ibrofen and u::m,
05           (0.6)
06    Com:   °Paracetamol.°
07    Pat:   >Yeah °Paracetamo[l°.
08    Doc:                    [How #many of those do you take on
09           average¿#
10           (0.7)
```

```
11    Pat:   I ta:ke one Bru:fen and a Paracetamol.
12           (1.8)
13    Pat:   when it sta:rts.=but sometimes it's really bad=I take
14           two Brufen (.) and a Paracetamol [and that's.
15    Doc:                                    [So on average per day
16           how many Ibuprofen?
17--> Pat:   I have 'em for probably three times a day but
18           sometimes [I just don't touch it.
19--> Com:             [It just depends he's having it four times a
20           day
21    Pat:   ((     ))
22    Com:    it just depends on how the headaches are.
23    Doc:    So you the the your doctor mentions Zopiclone
24            Omeprazole are you still taking those or?
```

In each of extracts 27 and 28 the patient's answer involves an estimate of frequency and in each case the companion responds with a higher estimate. In extract 27 the patient's answer at line 15 (and again at line 18) is minimising, as she is choosing the lowest frequency offered, "One a week", even in response to the doctor's repair initiation at line 17, "several a week". The companion's correction is at lines 19-20, offering a different estimate of the amount of times she has a seizure from the patient's "one a week", saying that "sometimes it can be a couple." This addresses and amends the patient's minimisation, without completely overriding her answer, as it suggests her answer is the minimum, although sometimes they are more frequent. He also adds an account, talking about the seizures not in frequency per week but in the maximum estimated time between them. This both suggests they often occur more closely together, but also accounts for the plausibility of the patient's answer.

In extract 28 the patient answers the question "so on average per day how many Ibuprofen?" (line 15-16) with an estimate of three times a day (though sometimes he just doesn't touch it) (lines 17-18). The companion's turn, starting line 19, upgrades this to four times a day, though qualifying that (" It just depends"), thereby aligning with the patient by suggesting that it can vary, but also increases the estimation formed in a similar way "he's having it four times a day". This increases the variation in medication to include a slightly higher number. In each case, therefore, the companion addresses the doctor, referring to the patient in the third person. Whilst correcting the patient, the estimation of frequency is only slightly different, and the correction is designed to align with the patient. However, in neither case does the companion seek the patient's confirmation through a tag question.

While there seems to be a tendency to upgrading an estimate, companions can correct frequencies by other forms without providing an explicit estimate of their own, as in the following case.

Extract 29 (from ext. 4 and 8) [162: Spouse: 13.52] (Times in A and E)

```
01     Doc:     So how often have you been to hospita:l?
02              (0.4)
03     ( ):     tch
04     Com      H[H]
05     Pat:      [f]hhh probabl=Well in the last six mo[nth]s?=
06     ( ):                                            [hh ]
07     Pat:     =the [las]t ye(h)a:r .h[h   [u:m ]
08     Doc:          [mm ]
09     Com:                            [ A a[nd E]:=
10     Doc:     =Mm:.
11     Pat:     >I don't know<=cos a lot of times I I won't stay
12              anyway=I just discharge m[yse]lf,
13     Doc:                              [mm ]
14     Doc:     So how often have you been to A and E?
15              (0.2)
16--> Pat:      U:m (0.2) I think I've been admitted three times. four
17              times.
18              (1.0)
19     Pat:     U:m ma:rch
20              (0.4)
21--> Com:       Na:h A and E's more frequent than that.
22              (0.2)
23     Com:     pr[obably.]
```

In extract 29 the patient's answer (line 16) is minimising by choosing to answer admittance to hospital rather than the number of times in A&E, which is what the doctor asked about. The companion corrects her answer in his turn at line 21, starting with a correction marker, "Nah". The use of a variation of a no-preface makes this correction more assertive. It flags there is something incorrect, or that the companion disagrees with in the patient's answer. Following the no-preface is an embedded correction, replacing "admitted" back with "A&E", before saying that it is "more frequent than that." This correction upgrades the patient's minimised problem presentation, with an answer that is more frequent, and also highlights the difference between admittance and A&E through an embedded correction.

In the following example, the patient plays down his anxiety concerning his memory loss.

Extract 30 (from ext. 14) [179: Spouse: 2.44] (Anxiety)

```
01   Pat:    The °only° thing since the first incident ter I have
02           lost my memory.
03           (0.4)
04   Pat:    Memo[ry's qui]te shocking.
05   Doc:        [ Y e : s]
06   Doc:    ye:s.
07           (0.6)
08   Doc:    .hh I'm afraid that seizures do upset memory=or
09           can upset mem[ory.]
10   Pat:                 [ Mm ] hmm.
11           (1.5)
```

```
12   Doc:    U:m are you getting anxious about it?
13           (0.4)
14-->Pat:    Not particularly anxious but Te(h)r
15           [J[ust   er  con]cern [me a ]little Bit]
16   Doc     [ [(                       )]
17-->Com     [He's not sleep]    [   h e 's  n o t] sleeping.
18   Doc:    Not sleeping=[so h]e h[es?
19-->Com:                 [No. ]   [I ]think >he's worried about it<
20           He he daren't fa:ll asle[e p.]
21   Pat:                            [(Wel]l) (0.3) since I- I had me
22           last seizu:re that was er >when was it< Friday=weren't
23           it?
24   Com:    M:m.
25   Pat:    Er since then I've had e:r two or three really good
26           nights=which is unusual.
```

Here the doctor asks the patient at line 12 if he is getting anxious about his memory. The patient's answer (line 14) minimises, resisting the stronger presupposition of his being anxious by downgrading "anxious" to a "little bit of concern". The companion's correction at line 19 is not an explicit correction or disagreement but an account providing evidence that suggests a contrary version "He is not sleeping." This is followed by an explanation at line 19, "I think he's worried about it, he daren't fall asleep." Her evidence that he is not sleeping, pushes back against the patient's minimising his worry, as not sleeping due to worry is a symptom of a more extreme emotion of anxiety rather than a little bit of concern.

Correcting by reporting contrary evidence highlights another issue with these corrections, which is the management of epistemic rights to correct details of the patient's symptoms and experiences. The patient might be considered to have primacy to knowledge about how stressed he is, and so to present an alternative answer the companion does work to provide her reasons for thinking he is more worried than he says, (that he is not sleeping), and also managing her claim to know by marking it as something she 'thinks'. The use of epistemic markers (Heritage, 2012), accounts following the correction, and tag questions seeking confirmation are common features in these corrections, though they vary depending on what the correction is about, as well as the companion's epistemic rights; for example, compared to extract 30, the companion's turn in extract 29 "Nah A and E is more frequent than that" is more assertive. However, he does add "probably" onto the end, which steps back a bit. In Extract 29, the companion's experience of how many times the patient has been to A&E is probably first hand, as someone who lives with her and possibly was involved in a few of these instances. In comparison in extract 30, the companion has less first hand access to whether the patient is worried about it, hence the epistemic marker "I think" (Heritage, 2012) and the use of evidential information "he is not sleeping".

In contrast, the following example shows a far more downgraded epistemic stance.

Extract 31 (from ext. 11) [184: Spouse: 03.40] (Family History)

```
01     Doc:     Um ch No he doesn't go blank on yo[u?
02     Com:                                      [N]o n[o he]s=
03     Doc:                                            [ No.]
04     Com:     =been fi:ne ever s[ince.]
05     Doc:                       [ Get ]up in the
06              [morning   and   do   thi]:s:?
07     Doc:     [((Demonstrates spasm  ))]
08              (0.8)
09     Pat:     °Not really.° ((shakes head))
10     Com:     °hm°
11              (4.6) ((Doc writing))
12     Doc:     Family history of any epilepsy?
13              (0.8)
14-->Pat:       No,
15-->Com:       Didn't you- (0.2) mum sa:y that your granddad=I think
16              (0.8) think your dad's dad had it?
17              (1.6)   ((Doc looks at Pat))
18     Pat:     °Epilepsy° ( o[h    )]
19     Com:                   [Ye    ]ah
20     Pat:      ye[a:h buet-]
21     Com:        [(       )] i'm [Su:re   i   di-  ]
22     Doc:                        [The first degree ]relative that=
23     Com:      yeah
24     Doc:     =vaguely ha:d.=u:m no: seizures in childhood?
```

In this extract, in response to the doctor's question at line 12 "Family history of any epilepsy," the patient's corrected response is "No" (line 14). The companion, his partner, is someone who is close but may not have direct access to knowledge about his family history, which is reflected in how she formulates her correction at line 15. It is tentative and formulated as a question. She frames it as an account of something those with greater epistemic rights to know his family history have reported, "I think" making the claim more tentative.

Other cases where the companion is more likely to manage and downgrade their epistemic stance when making these corrections are instances when the subject is about the person's mental state or experience. Extract 30 is an example of this, where the companion uses evidence to correct the patient's claim that he is only a bit concerned. This can be observed also the following extract.

Extract 32 (from ext. 6 and 17) [178: Spouse: 14.50] (Stress)

```
01   Doc:   =.hh I wonder what (0.3) a- you know (0.3) whether
02          stress has a_
03          (1.0)
04-->Pat:   [We:ll I'm,] I'm not really stressed am I:?
05   Doc:   [(        )]
```

```
06-->Com:   I don't kno:w=I think you- I think you are stressed
07          I thi[nk you ]
08   Pat:        [ With   ]Work li:ke.
09   Com:   Yea:h I think
10          (0.5)
11   Doc:   And what about a:l[l that's happened to you ]recently?
12   Pat:                    [We: ll   the   (struth ) ]
13   Pat:   the stress it's a worry (1.0) whe:n e:r (2.4) I'm off
14          Work=in't it?
15   Com:   Mm.
16          (1.5)
17   Pat:   And bills and that=but te::r (1.8) I can't can't see that
18          te:r cos some=you see when I (0.7) I have days off (0.8)
19          and e:r I forget about work I go- I like going fishing a
20          lot (0.6) °(somethin)° and when I go: fishing .h like
21          I've just been to Holland for ten da:ys
22   Com:   ((cough))
23   Pat:   A:nd I've never thought of work or nothi:ng
24          but e:very da::y (.) I got it th[ere:   ]=
25   Com:                                  [°yeah.°]
26   Pat:   =Same thing.
27          (2.4)
28   Pat:   So I went and had me eyes checked again
29          thinking it were me e[ye::s bu]t Hh no me eyes are OK=
30   Doc:                         [Mm hmm  ]
31   Pat:   =I just need glasses to rea:d=and I can't see when
32          I'm (0.2) you know writing close up.
33          (0.8)
34   Doc:   Is there any history of seizures at a:ll?
```

In extract 32 the patient has responded that "I'm not really stressed am I?" though gazing at the companion to seeking her confirmation. Her turn is in disagreement to his, firstly prefaced with "I don't know", withholding confirmation without directly disagreeing with him; this is followed by an account. Epistemic markers like "I think" downgrade her stance (Heritage, 2012), while still disagreeing with him. It is also a little different in that he has invited input from her, but her turn still provides contrasting detail, addressing and correcting the minimising work of his turn by offering an alternative upgraded version/account.

In all the cases I have shown, the movement that corrects the minimisation of the patient's turn has been designed to be slight. Either by providing one symptom, suggesting the patient's answer is not always the case, adjusting (increasing) the frequency estimate by one, or just saying that there is more than the patient's answer suggests, these corrections are designed to redress the minimisation of the detail in question, but in a way that is still somewhat aligning with the patient.

In the following extract, which is an outlier there are two corrections in sequence, both differ from this pattern. The first correction occurs at lines 01-05 and the second at lines 63-69.

Extract 33 (from ext. 12 and 15) [064: Spouse: 21.18] (Headaches)

```
01    Doc:     And do you take any tablets at a:ll?
02    Pat:     No: on the contraception pill °that's it°
03    Com:     na- ah wa Be truthfu:ll. What do you take
04             all ti:m[e?]
05    Pat:             [ O]h Ibuprofe:n f[or ah] m migrai:ne.
06    ( ):                               { sh  ]
07    Doc:     hmm mm so you've got a problem with headache.
08             (0.4)
09    Doc:     y[eah?]
10    Pat:      [ Yea]:h migraines yeah
11    Doc:     So what happens with the hea headaches?
12             (2.0)
13    Pat:     U:::m I get migraine (0.2) u::m (0.2) someti:mes I
14             lose me vision with that.
15             (1.4)
16    Doc:     And how often do you get migraine?
17             (1.0)
18    Com:     Well put it this wa:y=we go through u::m (0.2) about
19             a hundred tablets a wee:k,
20             (1.0)
21    Doc:     So do you (0.2) you ha:ve headache all the time?
22             (0.4)
23    Pat:     °Near enough yeah.°
24             (2.4)
25    Pat:     U:::m
26             I g[et vomiting as we:ll with me migraines.]
26    Com:        [a- a-  a-  and that's fou:r  hundred mi]lligrams
27             of Ibuprofen,
28             (0.2)
29    Com:     that's t- two tablets in one go every ti[: me . ]
30    Doc:                                            [Can you] tell
31             me a bit mo:re about the headache,
32             (0.4)
33    Doc:     so: what's it like?
34             (0.2)
35    Pat:     U::m it sta:rts whe:re u:[:m     i ]t's all in=
36    Com:                              [((groan))]
37    Pat:     =>front of me head,<
38    Doc:     Mm [hmm.]
39    Com:        [KHHh]h[hh]
40    Pat:             [A:]nd then (0.8) I cAn't stand listening to
41             anything.
42             (0.5)
43    Pat:     If [I lo]ok at anythi:ng me vision goes.
44    Doc:        [ mm ]
45             (0.8)
46    Pat:     I go: and la:y do:wn in bedroom,(0.4) so it's a:ll
47             black,
48             (0.8)
49    Pat:     u::m (0.2) >and then I< (0.2) I vomit,
50             (0.4)
51    Pat:     ba:sically.
52             (1.6)
53    Doc:     And how often do yo:u have to lie do:wn and=or how
54             often do you vomit?=how often does it get that ba:d,
55             (0.8)
55    Pat:     Couple of ti:mes (0.2) a week.
56             (8.0)
57    Doc:     And on th the rest of the da:ys?
```

```
58              (3.0)
59    Pat:      >I can get< U:::m (0.2) bits of headaches but it's not
60              as bad as the actual mi:gr[ai:]ne itself.
61    Doc:                               [mm ]
62              (0.4)
63    Doc:      But you take Ibuprofen every day?
64              (1.2)
65    Pat:      If I get a headache yes
66               (0.8)
67    Com:      No sh[e takes a-}
68    Pat:           [ It's  the] only thing=
69               tha[t   (     )    that   gets] rid of it
69    Com:          [She tAkes them E:very day.]
70    Doc:      Mm.
71               (0.6)
72    Pat:      I can't take >Paracetamol that doesn't
73               d:o anyth[ing<.]
74    Doc:                [  Ho]w many do you take in a day?
75               (0.5)
76    Com :     eight hundred mil- about eight hundred milligrams
78               e::r and that's in a mo:rni:ng and  eight hundred
79               milligrams and that's in an afternoon.
80               (0.4)
81    Doc:      Mm  hmm.
82.              (4.0)
83    Doc:      Any other tablets?
84               (0.2)
85    Doc:      No?
86               (0.2)
87    Pat:      No.
```

The first correction of this extract (lines 01- 06) follows a similar pattern; the patient's answer is a "no " following an "any" question, adding only the mention of the contraceptive pill (line 2). The companion's turn at line 03 does something different from what has been shown previously; it does not offer an alternative but instead prompts the patient to change their answer. The turn also characterises the patient's previous answer as not just incorrect but dishonest, telling her to "be truthful", before prompting her by asking "what do you take all the time." This characterises the patient as knowing the answer and deliberately avoiding saying it. The correction is also framed as an extreme case formulation "all the time," indicating that she should know this.

In the second correction of this extract (lines 63 -39) the patient's answer minimises her "yes" to taking Ibuprofen every day, by making it conditional (line 65). The correction at line 67 is similarly a "no" prefaced correction, making it more assertive. The use of a 'no' preface in the correction highlights there is something about the patient's answer that needs to be corrected. At line 69 the companion upgrades the patient's answer back to "she takes them every day," thereby deleting the patient's minimising conditional statement.

In this extract, especially in the first correction the companion's turn is more disaffiliative. It also provides a contrast with previous examples, showing that while they are adjusting or challenging the patient's answer, the previous examples tended to be formulated to do so in a way which is affliative, often adjusting or including the patient's answer. They do not directly challenge the patient, or characterise the patient as wrong or dishonest. This shows how the use of this kind of correction as a mechanism can be used by the companion to be supportive of the patient's account, (though pushing back against their minimisation) in a way that expresses minor disagreement or doing "reminding", or use the correction to criticize or accuse the patient of something more normatively bad.

Overall these cases all are corrections focused on correcting the patient's minimisation; they do so by adjusting details of the patient's answer in their turn, and moving towards a more upgraded problem presentation. In some of these cases, the adjustment is slight, and is often constructed so as not to completely contrast with the patient's answer.

The patient can minimise their answer in a number of ways, by giving a no symptom answer (as in extract 7) or answering in a way that minimises the frequency (as in extract 8) or giving a conditional (extract 15). This is not to say that the patient always minimises symptoms in response to the doctor, but that in these cases, the upgrading correction is in response to the minimising aspect of the patient's turn.

When the patient provides a "no problem" answer the companion upgrades slightly by suggesting a symptom. In others, when the patient makes a statement which minimises their problem presentation the companion can use an increment to adjust the patient's response suggesting that it is "not always " as good as the patient suggests as seen in extracts 25-26. In extracts 22, 27 and 28, the companion corrects the minimising by the patient by offering an alternative estimate of frequencies that raises the frequency the minimum amount upward (only one number difference). In extract 29 this is done more assertively using a no-prefaced correction to highlight that the estimation is "more frequent" though he does not give his estimation of frequency. This turn is less aligning, as the position the companion takes with their turn is less inclusive of the patient's original answer, giving a stronger stance that her turn is "incorrect" in some way.

This tendency to include or align the companion's versions with the patient's versions can make the waters a bit murky when looking at them as corrections. However, in a sense in all these cases the companion treats the minimisation in the patient's answer as "incorrect" or "not right" and therefore as grounds to interrupt the progressivity of the talk. The formulation of these corrections can also manage epistemic stances; mitigation of epistemic stance is

related to what the question is asking and whether the companion has first-hand rights to know. In extract 29, the companion is more assertive in their correction about the frequency of hospital visits, which is something they are likely to have experienced with the patient, and therefore have more a higher epistemic claim than. The companions in extract 30 and 32 who are correcting the patient's answer about the patient's mental state (stress and anxiety), something the companion has less epistemic rights to claim. In extract 30 and 32 there are more epistemic markers where the companion manages this. Similarly, the companion downgrades her epistemic stance when correcting the patient about his family history, something he has more rights to claim knowledge about. Extract 33 shows that the corrections can be used to do things besides just correcting. In this case there is a level of accusation that she is hiding how many painkillers she is taking.

5 Discussion

This chapter has examined cases where companions 'upgraded' patients' talk when that talk minimised or downplayed the severity of a symptom. It thus marks a major step towards the aim of this thesis (to examine the companion's role in the seizure clinic) by highlighting a specific kind of contribution that companions make.

Section two discussed the overall three-stage sequential pattern around these corrections, as follows:

Stage 1: The doctor asks a diagnostic question

Stage 2: The patient answers with a no-symptom report or downplaying symptomatic severity

Stage 3: The companion corrects the patient's answer, upgrading the symptomatic severity

Subsequent sections then looked at the second and third stages of this sequence in detail. Section three, first of all, focused on how patients frequently answered doctors' questions about their symptoms by downplaying them. Doctors' questions could be either yes/no interrogatives or open-ended, but when the question was open ended it tended to occur as part of a longer sequence where the patient's previous answer had been insufficient. Patients consistently, as part of this sequence, responded to these questions with a 'no problem' or minimizing answer. While question design and contiguity did play a role in how patients

formulated their answers, some patients were demonstrably pushing back against how the doctor's question was formulated in order to be minimising. This finding is consistent with work by Heritage and Robinson (2006) who showed how patients, when accounting for their visits, strike a balance between on the one hand presenting their concerns as legitimate and therefore worthy of the doctor's attention, while on the other hand presenting themselves as stoic (i.e. uncomplaining). It is also consistent, more broadly, with Jefferson (1980) who observed how speakers can avoid making "an undue fuss" about their troubles when relating them to others, a stance that she referred to as "troubles-resistant" (p. 165-166).

Section four then focused on the design of companions' upgrading corrections and how they corrected the patient's answer. It showed how companions oriented to the patient's no-problem or minimizing answer as needing correction. It also showed, though, how companions often designed their corrections in a way that still aligned with the patient's answer. The companion's corrections were designed to upgrade the reported severity of the symptom. When the patient's answer was a no-symptom answer, the companion upgraded it slightly by providing a symptom. When the patient's answer minimised the symptom frequency, the companion often upgraded the frequency only by one increment (e.g. turning two times to three times). This demonstrates that the correction is slight.

Research on companions has often asked whether they are useful to a consultation (Laidsaar-Powell et al., 2013; Schilling et al., 2002; Wolff et al., 2016; Wolff, Roter, et al., 2012). This chapter has provided evidence in favour by showing how companions can provide alternative versions of events (albeit versions that have often been only slightly adjusted) to which the doctor would not have had access had they not been present. This chapter has thus shown one of the ways in which companions can contribute to consultations by providing informational support (Ellingson, 2002; Laidsaar-Powell et al., 2013). The next chapter will now show another way in which they can do so – by contributing to discussions about the patient's medication.

CHAPTER 5 COMPANION'S CONTRIBUTION TO MEDICATION DISCUSSIONS

1 Introduction

In the course of analysing this data set, medication repeatedly emerged as a topic to which companions contribute. Medication is a typical and expected part of medical consultations, and is a matter to which both patients and doctors orient (Stivers, 2007)., The companions in this data set not only demonstrated knowledge about the patient's medication, but also showed initiative in facilitating discussion about a prescribed medication.

This study used videos of 30 accompanied consultations (patients accompanied by one or more companion). Medication was discussed in all of these consultations, routinely as part of history-taking, but also sometimes as part of treatment.

The following table (*Table* 5.1) shows the distribution of consultations where companions contributed to medication discussions compared to consultations where they did not.

Table 5.1 Companion Participation in medication discussions

	Interactions Where Companions Contribute	Interactions Where Companions **Do Not** Contribute	Total
Number of Interactions (videos)	67% (n=20)	33% (n=10)	30

Companions contributed to talk about medication in 67% (just over two-thirds) of the interactions (Table 5.1). This figure includes consultations where the companion contributed multiple times. When discussion of medication occurred, it occurred in the *history-taking* and *treatment recommendation* phases. The following table (Table 5.2) displays the percentage breakdown of where the companion's contributions occurred.

Table 5.2 Percentage of where companions participate in discussions about medication

Companion **only** Participates in HT (History-taking)	Companion **only** Participates in TR (Treatment recommendation)	Companion Participates in **both**	Total
40% (n=8)	25% (n=5)	35% (n=7)	20

In Table 5.2, companion participation in medication discussions occurred most often in history-taking. In 15 out of 20 (75%) consultations where the companion contributed to discussions about medication, one or more contribution occurred in the *history-taking* phase. This figure takes into account that medication as a topic can be introduced more than once in a consultation. It combines both the 40% (n=8) of companions who **only** contributed in the *history-taking* phase and the further 35% (n=7) contributed to discussions on medication in both *history-taking* **and** *treatment recommendation* phases.

Contributions to medication discussions in the *treatment recommendation* phase occurred less frequently at a total of 60% (n=12) combining when companions participated only during the *treatment recommendation* phase (25%, n= 5) and in both *treatment recommendation* and *history-taking* phases (35% n=7).

The higher frequency of companions contributing in history-taking as opposed to the treatment recommendation phase is in part because the discussions of medications were more likely to occur in the history-taking phase. Questions about medication in history-taking were procedural and occurred in every consultation, while in treatment recommendation, medication being raised was contingent on the diagnosis and the patient's current treatment. For example, when the patient was diagnosed with non-epileptic seizures, the treatment recommendation was more likely to be psychotherapy rather than anti-epileptic drugs. Therefore, medication was less likely to be mentioned in treatment discussion when this was the case. There were also a few instances where the diagnosis was uncertain, so further tests were recommended.

The following sections will explore how companions contribute to and participate in discussions about medication by examining their contributions in the history-taking and treatment recommendation phases. Analysis will show how the function of these contributions, and how they come about, differs depending on where they are in the consultation. In the *history-taking* phase, companions act as a resource for both the patient and the doctor. In the treatment recommendation phase, on the other hand, companions take the initiative in pushing for talk about medication. Both types of contribution show that companions are not supine or uninterested bystanders. Rather, they have an interest in decision-making regarding medication, and take opportunities in the closing phase of the consultation to initiate discussions about what they orientate to as important.

2 Medication in history-taking

As stated previously, questions about current medication are a routine part of seizure clinic consultations. They are an expected part of the consultation, not only for the doctor but also for the patient. This is evidenced by the fact that many patients will bring their current prescriptions, if they have any, with them to the visits. This section examines what is happening in the 14 consultations where the companion contributes in the history-taking phase. The following subsections look at the role of the companion as a resource for the patient and doctor (2.1), as someone who can respond to patient difficulties (2.2), and as someone who can add information to an answer a patient has already given (2.3).

In history-taking, companions' contributions tend to be used as a resource for information. Companions act as witnesses who have knowledge about the patient's medication, and their medication taking habits. Sometimes their contribution supports the patient's account; sometimes their contribution comes in the absence of one from the patient. Companions often intercede to answer these questions when the patient is unwilling or unable to do so. In these moments, there is a balance between the companion having the information and the patient's right as the principal respondent (Tiitinen & Ruusuvuori, 2012) to questions.

2.1 The companion as a resource

The companion's relationship to the patient affords them first-hand knowledge about the patient's medication. It also accounts for them having an interest in knowing about what the patient is on, what their dosage is, and how often they take it, especially if they are caregivers. This knowledge can be useful to both the doctor and the patient. The following extract shows how, due to this shared knowledge, the patient can recruit the companion to help answer questions when they are having difficulty.

Companions are a resource for both patients and doctors, providing an alternative source of information . Their contributions are, however, still balanced with the patient's primary rights to knowledge,and they do not not usually answer on behalf of the patient. In cases where it appears that this is the case, there are often contextual factors at play that mitigate the patient's primary rights, including the following extract (extract 1). In this extract, the companion was in possession of the lists of the patient's medication, and other such paperwork. The companion's access to knowledge about the patient's medication was not limited to possession of these lists, but being in possession of them means that, when the doctor asked for the list, they have an established entitlement to answer on the patient's behalf.

Extract 1 [155: Spouse: 2.35-5.22] (Drug List)

```
01.   Doc:  Goo:d, My name's ((doct[or's name)),(0.8) and I work=
02                                 [((turns gaze to notes))
03    Doc:  =with ((doctor's name)), (1.5) a:h just let me (3.6)
04          have a look he:re, (6.7) quite a list of tablets
05          that you're on?
06.   Pat:  Yeah, (.) yeah but they have been cut do:wn lately.
07          (0.1)
08    Pat:  Me wife has (got) prescriptions (on her).
09          (5.1)
10    Doc:  Okay Let me just have a few basic
11          details down first.=How old are you now?
12.   Pat:  (Er er) fifty-nine,
[
[……Lines omitted from history-taking phase……..
[
14    Doc:  um a:nd there's something about your liver and alcohol.
15          What's the problem there?
16    Pat:  I was drinking er far too much at one time.
17    Doc:  And you've cut down now?
18    Pat:  I've cut right down.
19    Com:  He hardly drinks now.
20          (2.8)
21    Doc:  No:w your drug list, (1.2) Is
22          Omeprazole?
23    Com:  Yeah.
24          (1.8)
25    Doc:  Temazepam?
26    Com:  Yeah.
27          (0.8)
28    Doc:  Ramopril?
29          (0.6)
30    Com:  Yeah.
31          (0.8)
32    Doc:  Milisartin?
33    Com:  Yeah.
34          (1.7)
35    Doc:  Elopurinol?
36          (0.9)
37    Com:  Yeah.
38          (1.1)
39    Doc:  Nephepam?
40    Com:  Yeah.
41          (1.5)
42    Doc:  Dihydrocodeine?
43    Com:  Yes.
44          (1.1)
45    Doc:  Frusimide?
46    Com:  Yes.
47          (2.2)
48    Doc:  Ruvastatin?
49    Com:  Yes.
50          (2.5)
51    Doc:  Diazepam?
52    Com:  Yes.
53          (1.5)
54    Doc:  Dispirilone?
55          (0.8)
```

```
56    Com:  No. He's not on that one now.
57    Doc:  Okay, U:m fe[(no-)
58    Com:              [But he's on another one thou:gh.
```

When the doctor asked about current medications (line 21), the companion answered immediately (line 23), and there was no resistance from either the doctor nor patient to the companion answering. The companion's immediate answer occurred in a context where the patient had previously established the companion as the principal respondent to medication questions because the companion was in possession of the drug list (lines 01-13). The doctor was also in possession of a list of medication the patient was on. At line 02 he turned his gaze to his notes, and at line three, while still looking at his notes, commented on the amount of drugs the patient was on. When doctor questioned the companion on the list of drugs (lines 21-58), it was to verify the list he had in his notes against the list that she had. For each turn, he read a drug off his list and the companion confirmed, looking at her own.

When the doctor reintroduced the topic of the drug list on line 21, he did so by orienting to the earlier talk (lines 03 08, where the patient indicates the companion has his prescriptions) by referencing the drug list. By referring specifically to the list, rather than medication in general, he selected the companion as having the primary role to respond, because it was already established that she had the list.

As each medication was named by the doctor and confirmed by the companion (lines 21-57), the patient took a bystander role; he did not participate in confirming the list. The patient's absence in the discussion was especially apparent at the end of the extract (lines 56 and 58) where his wife talked about him in third-person ("No. He's not on that one now.") By using the pronoun "he", she designed her talk to be directed at the doctor and answered on behalf of the patient.

Talking on behalf of the patient in this way parallels other instances of caregiver role interactions, e.g., paediatric consultations (Stivers, 2001; Tates & Meeuwesen, 2000). To speak on behalf of a patient is a delicate thing for a companion to do. Most companions orient to the patient's primary rights to answer for themselves, and, when they answer for the patient, doing so is contingent on having shared rights to the answer (e.g. a spouse might answer questions about children or marital status). In this case, it is both her primary access to the list and that the patient has previously indicated she is in possession of it that contextually gives her primary rights to confirm what is on it.

However, companions do not need physical lists to have access to knowledge about the patient's medication. They often have access to knowledge about medication because they

live with and/or a caregiver to the patient, and have thus witnessed them taking it. They also do not need to be in possession of a drug list to be given opportunities to share this knowledge: patients and doctors can recruit companions to share it, making them a resource for these other parties.

In extracts 2 and 3, companions are recruited by the patient to help answer questions about medication.

Extract 2 [173: Parent: 13.17- 15.29] (Counselling and sleeping tablets)

```
Doc:  What happens in the panic attacks?
      (1.0)
Pat:  I just don't like to go ou:t I start sweati:ng (0.3)
      fidgeti:ng (1.8) U:m .hhh I'm trying to sort out being-
      feeling depressed (2.0) feel very well °all the time° at
      the moment which I'm trying to sort out with me GP?
      (1.2)
Doc:  Have you ever taken tablets for depression or
      [ever ha]d any treatments?
Pat:  [ Y e s ]
Pat:  Yeah u::m. (( Turns to companion))
      (0.7)
Com:  Well they wanted to put her on sleeping tablets and we
      said n:o because .hh u:m her daughter's got ADHD so:
      there's no way she can have sleeping tablets.
Doc:  Mm:
Pat:  A:nd I've been on oh I've forgot what they a:re now.
      (0.9) I were o:n summat that knocked me out at ni:ght
      years ago: can't remember their na:me and I've been o:n
      two or three (1.0) d[iff]erent ones.
Doc:                      [mm ]
Doc:  But not recently,
Pat:  Not in the last year.
```

Extract 3 [178: Spouse: 5.04- 6.00] (What medication am I on?)

```
Doc:  Any other medical problems in the past?
Pat:  N:o no E:r I th[ o u ght. ]
Doc:                 [Are you on] any medication?
Pat:  Only e::r  what=((Patient turns to Companion))
Com:  =Just like your back a:nd knee a:nd
Pat:  What medi[ca]tion am I on?=Arthr[otec.]
Doc:          [d-]
Com:                                [Arthr]otec
      C:o-dydramo[:l     ]and Glucose=I mean >they're=
Pat:             [(mol)  ]
Pat:             [((Nod))]
Com:  =j[ust °vi]tamins aren't they though°<.
Pat:    [ Yeah  ]
Pat:    [((Nod))]
```

In Extracts 2 and 3 there is evidence that both the companion and the patient orientated to the companion's knowledge about the medication. In both cases, the patients displayed some

difficulty in answering, before turning their gaze to the companions to recruit them to help answer. In Extract 2, lines 10-11, the patient displayed difficulty answering the doctor's question on medication. In response to the doctor's question ("or ever had any treatments",lines 08-09), the patient answered affirmatively, first in overlap (line 10), then again in the clear ("Yeah") (line12). The patient's response was insufficient to describe what exactly the treatments were, however, with her drawn out "u::m" (line 11) both orientating to this insufficiency and displaying her difficulty in elaborating (Clark & Fox Tree, 2002). The extended "um" coincided with her turning to look at her companion (her mother), both of which recruited her to help answer (Kendrick & Drew, 2016; Stivers & Rossano, 2010). In Extract 3, the patient showed similar difficulty before turning his gaze towards the companion (line 04). The patient's answer at line 04 started with "only" but did not finish. Instead, he turned his head towards his companion with a long "e:rrr" signaling difficulty (Clark & Fox Tree, 2002). He then prompted the companion to answer the question by saying "what" (line 04), accompanied by a quizzical expression.

In both extracts, the companions are recruited to help answer the question after the patient has turned to them (line 13 in extract 2, line 05 in extract 3). In extract 2, the companion's contribution (lines 13-15) suggested what she oriented to: the ambiguity over what treatments the patient has had, due to the patient's earlier refusal to try sleeping tablets. That there was a problem with the presupposition of the doctor's question can be seen in both well-preface (Heritage, 2015) and the extensiveness of the answer.

In extract 3, the companion's response to the patient's recruitment was at line 05. The following repair sequence (lines 06-08) indicates that the companion's initial response was not quite what the patient was trying to recruit at line 04. The repair sequence consisted of the patient's clarifying question at line 06: "What medication am I on? Athrotec". The patient included the beginning of a list of medication (Athrotec) as part of the question design, indicating the type of answer they were seeking. This extract shows a progression from a more open recruitment, using gaze and an open "what", to the more specific questioning of the companion. The companion responded with the information, first repeating the drug the patient mentioned ("Arthrotec,") before adding " Co-dydramol and Glucose". Repetition of the drug that the patient had suggested both confirmed it and pre-framed the other drugs as part of the list that the he had started.

These extracts show patients orienting to companions as a resource when they are having difficulty. The companion is shown in both cases to have knowledge about the

patient's medication and to be able to provide support in answering these questions by providing something that the patient can either confirm or build upon.

In both extracts 2 and 3, the patient's next talk confirmed the companion's contribution. In extract 3, this was done non-verbally at line 11, when the patient nodded, and explicitly at line 13, with "yeah". In extract 2, the patient implicitly confirmed the companion's answer by prefacing their next response with "and" (line 17). Even though their answer offered slightly different information, the "and" designed their turn on the previous, rather than contradict it.

The way the companions designed their contributions, and the way both patients confirmed these contributions, suggests that both parties treat this answer as being in the patients' epistemic domain (Heritage, 2012). There is evidence for this throughout these extracts in, for example, the fact that in most cases the companion will only contribute to talk about medication *after* the patient has been given a chance to respond to a doctor's enquiry.

2.2 In response to patients' difficulties answering doctors' questions about medication.

Previous extracts have shown the companion contributing after having been recruited by the patient's gaze or an explicit invitation (question); it is also possible, though, for a companion to intercede to answer a doctor's question without an express or explicit invitation to do so. In the following cases, the companion is not explicitly invited to answer a question but still recognises that the patient is having difficulties answering. In extracts 4 and 5, the doctors are pursuing a follow-up question, which leads to trouble for the patients. It is in this space, created by the pursuit, that the companions contribute, fixing what they perceive to be the insufficiency in the patients' responses.

Extract 4 [169: Spouse: 12.23-12.48] (One tablet 10 mgs.)

```
01     Doc:  Do you take any medication at all?
02 ->  Pat:  [O  n  l  y  ][what the doctor's prescribed me for no:w.
       Pat:  [((glaze down][Gaze back at doc))
03     Doc:  So that's the Amitriptyline?
04     Com:  Yeah.
05     Doc:  And what dose?
06           (0.3)
       Com: (( bends down to purse))
07 ->  Pat:  [On:e
       Pat:  [((gaze on com ))
       Com:  [ ((picking up purse))
08     Doc:  One tablet=how many mil (  ) t[wenty five?]
09     Com:                               [[ Yea:h   [u:]m
       Com:                                          [((look through
```

```
            [bag  ]) [((Pulls out box))
10          [(2.7)   [(0.8)
11    Com:  [Yeah u:m one tablet 10mgs u:m at night before
    Com:    [((looking at medicine box))
12           he g[oes] to bed.
13    Doc:       [mm ]
14          (0.8)
15    Doc:  Do you work?
16          (0.4)
17    Pat:  Not at the moment doctor's signed me off
```

In Extract 4, the companion contributed (line 04) after the doctor rephrased a question to clarify or pursue a detail that was not covered sufficiently in the patient's original answer. In response to "Do you take any medication at all" the patient had answered "what I am prescribed right now". This answer was designed to be understood in the context that the doctor had the patient's medical records in front of him, but the answer did not quite fit what the doctor is seeking. Usually, when the doctor asks this question, the patient will answer with the name of the drug or what it is for. For example, the following extract from another consultation.

```
01    Doc:  So tablets, are you taking any medication?
02    Pat:  The only thing I'm taking is Clexane.
03    Doc:  Right.
```

In extract 4, the evidence that the patient's answer is insufficient is in the doctor's confirmation-seeking follow-up question at line 03:"so that's the Amitriptyline?". The companion, perceiving the patient's answer as insufficient, answered for him at line 04. This contribution was still not all the information that the doctor needed, however, evidenced by him seeking further clarification about the exact amount the patient is taking at line 05.

The second contribution by the companion at lines 09-12 was similar to her contribution in line 04. It comes after another follow-up question from the doctor (line 08), in response to an insufficient answer from the patient (line 07). There is evidence that the companion was already preparing to answer, as she began to bend down and reach for her purse after the doctor's question at line 05. The patient began to answer at line 07: "with "on:e"), This was extended and, as he was producing it, his gaze shifted to watch his companion as she reached for her purse. It is possible that both patient and companion were orientating to the information being available in the bag, and therefore about to be retrieved by the companion. The patient's response of "on:e" is possibly incomplete, therefore, because it has been dropped in favour of waiting for the companion to retrieve the information.

The doctor did not orientate to the companion getting her bag and instead pursued a more detailed answer to another follow-up question. This question completed the answer to what he interpreted the patient meant by “one” and then asked for the specific dosage in milligrams, giving a candidate amount. The companion began in overlap (“yeah um”, line 08) as she looked through her bag, bringing it onto her lap so the doctor could see it. Her utterance acknowledged the question with its extended syllables, which visibly displayed that she was searching for the answer to his question. She repeated the “yeah um” before, finally, answering at line 11 by reading from the box of medicine that she had retrieved from her bag.

She both confirmed that it was one tablet and added what time he takes it (before going to bed at night). Within her answer, there was an embedded correction (Jefferson, 1987) of the amount of milligrams the tablets are (10 milligrams), which is different from the quantity suggested by the doctor (“twenty five” miligrams, line 08). Her right to answer instead of the companion was displayed, as it was in extract 1, with her physical possession of the information. It is possible that the patient’s earlier quick glance at line 02 was orientating her having the prescription information in her possession.

In this case (especially at lines 01-05), the patient had been given an opportunity to answer both of these questions,. However, the pursuit by the doctor created a sequential context where the patient’s answer was shown to be insufficient. In this way, these extracts are similar to Extracts 2 and 3, where the companion contributed or took over answering in circumstances where it was apparent that the patient is having difficulty.

The companion’s possession of the information was not made explicit in the same way as extract 1. Both the patient and the companion oriented to her looking for the information, but the patient was still treated as the principal respondent by the doctor. Her visible searching, combined with the patient’s difficulty answering immediately, helped to generate the doctor’s second follow up question at line 08.

Extract 5, further illustrates how the doctor's pursuit of an answer and the patient displaying difficulty create a sequential context in which the companion can contribute to answers about medication.

<u>Extract 5 [167: Spouse: 15.28- 17.29] (“You’ve had seven in a week”)</u>

(The patient has just given a list of medications she has been prescribed, showing a prescription list.)

```
01    Doc:  Any other tablets?
02    Pat:  Yeah I’m on er (2.0) Temazepam and
```

```
03          Dihydrocodeine (2.8) and er (0.5)
04          I'm a- I'm asthmatic.
05    Doc:  Mm how much Dihydrocodeine?
06    Pat:  E:r (1.2) I get forty: two (0.9) e:r for ove:r (1.3)
07          >Well< I get the prescription each week but don't always
08          nee:d_
09    Doc:  So how many do you take on average?
10    Pat:  U:m,
11          (1.5)
12    Com:  ((   )) you've ha:d seven in a, a week=
13    Pat:  =No that's sl[e e p e r s.]
14    Com:               [That's your ]sleepers.
15          (0.4)
16    Pat:  U:m it can depend if I've e:r if me back's playing up=
17          which is what they were orig[ina]lly prescribed for.
18    Doc:                              [Mm.]
19          (0.7)
20    Pat:  I could e:r take four (.) to six a day.
21          (3.7)
22    Doc:  And how much Temazepam?
```

It is common for follow-up questions to occur about dosage because, while the doctors are often seeking a very specific way of describing dosage, patients can answer ambiguously. In Extract 5 this is illustrated by how, when the doctor asked, "how much Dihydrocodeine" the patient had been taking, the patient's answered with what she was prescribed per month (lines 06-07) rather than her dosage per day. The design of her turn has several features indicating that she was having difficulty answering. These features include the restart of her turn (from "I get forty two for over" to " Well I get the prescription each week"), the sound stretches on ("E:r", "Forty:" and "ove:r") (Clark & Fox Tree, 2002), and the pauses in her turn. The "Well" preface indicated that the answer goes against some of the presuppositions of the question (Heritage, 2015), and this did indeed turn out to be the case, as the patient explained that she was *prescribed* a certain amount, but that the amount she *takes* varies. While the patient's answer (lines 06-07) may have been be accurate from the perspective of her experience, it was not sufficient for the doctor, as evidenced by his follow-up questioning (line 09) asking her to estimate an average she takes (see Lindström and Weatherall,(2015) on the distinction between the epistemics of experience and expertise).

The patient displayed further difficulty in answering this follow-up question (lines 10-11). Her "u:m" vocally indicated that she was searching for an answer (Clark & Fox Tree, 2002), and gaze was directed up slightly which embodies thinking (Goodwin & Goodwin, 1998). This was followed by a long silence (1.5 seconds).

It was after this (line 10-11) display of difficulty that the companion contributed. His turn was designed to be directed at the patient, and to function like a prompt: "you've had seven in a a week" (line 12). The subsequent exchange (lines 13-14) occurred because it

turned out he had misidentified which drug they were talking about. This was repaired by the patient (line 13), which the companion repeated in a post repair confirmation (line 14) (Jefferson, 2007) . After this exchange, the patient went back to answering the doctor's question. While she did not give the requested average, she did explain the conditions when she takes them, and thus why it was difficult for her to estimate what she takes on average.

This extract also shows the companion contributing after the patient has shown difficulty or unwillingness in answering a question about medication. It shows how, in these cases, the patient was still treated as having primary rights to answer. After all, the companion's turn was designed not to be directed at the doctor or answer *for the patient*, but to be directed at her as an aside, with the doctor being the overhearing party. In this way, the line of questioning in the consultation remains, for the most part, a two-person interaction between the doctor and the patient. The companion's role is to support the patient's role in the questioning.

2.3 Adding and adjusting the patient's Answer

Apart from answering for the patient, companions also expand, confirm, or correct a patient's answer. These cases are a mixture of the companion orientating to some trouble with the patient's answer, to remedy their insufficiency, and making them more specific.

Extract 6. [162: Spouse: 16. 01- 16.25] (more for the pain)

```
01    Doc:  what treatments have you had for the weakness?
02    Pat:  I'm on u:m at the moment I'm on Gabapenti:n (1.5)
03          Tramadol slow release and I'm on Citalopram.
04          (0.3)
05    Com:  That's f[or the pain more >isn't it?<]
06    Par:          [Which   is  more  for  the p]ain to be honest.
07          (0.8)
08    Doc:  What pain?
09    Pat:  Back pain.
10          (1.8)
11    Doc:  Is that since the coll[apse? or ]have you had that=for
12    Pat:                       [Y e   a h]
13    Doc:  =for longer.
```

In extract 6, the companion's contribution is at line 05. This is a clear example of the companion using their knowledge of the patient's medication to correct the patient's turn. In responding, they oriented to some trouble in the patient's answer, and used the next turn to clarify the use of the medication the patient had mentioned. The patient also displayed difficulty in her turn; as in previous extracts there is an extended "U:m," (Clark and Fox Tree,

2002) and a long pause (lines 02-03). The trouble the companion was addressing with their correction was the function of the medication. There was difficulty because it was hard to say from the patient's answer which of the three drugs she listed was treating her "weakness". There is in fact some indication that the patient herself was having difficulty in selecting the specific drug for weakness in her long pause after "Gabapentin". The manner of the patient's confirmation is further evidence of how, even in these sequences, the patient is the principal respondent and the companion's role is supportive.

The correction from the companion (line 05) came after 0.3 seconds of silence. The companion hedged the correction with "more" rather than a direct negation like "It's not for weakness it's for pain", which downgraded the assertiveness of it. By suggesting that the medication was "more for the pain", it left open the possibility that the medications were for both weakness and pain. The tag question, also downgraded the corrective nature, by designing it to seek confirmation from the patient, therefore treating it as within the patient's epistemic domain (Heritage & Raymond, 2018).

The companion's correction also seems to be primarily directed at the patient, as an aside. Certainly, the patient *treats* it as such by offering a post-repair confirmation (line 06). This confirmation was formulated with full repeat of the companion's turn, followed by "to be honest", directed at the doctor. The "to be honest" indexed that the her previous answer, the list of medications, didn't quite fit the doctors question (Edwards & Fasulo, 2006), By doing this, the patient not only accepted the correction but took ownership of the companion's words, bringing the discussion back to herself and the doctor. When the doctor asked a follow-up question, the patient responded, and the companion returned to being an observing bystander.

In the following extract, the companion used the space after the patient answered to add more information about his medication and the symptoms he had, using an "and" preface to do so.

Extract 7. [089: Spouse: 1.48-3.31] (Too many to remember)

```
01    Doc:  Do you have a bit of high
02          blood pressure?
03          (2.6)
04    Pat:  I believe so.
05    Doc:  A::nd
06    Pat:  (        )
07          What do you take Betahistine for?
08          (1.2)
09    Com:  Oh,
```

```
10    Pat:  U:m (1.3) I think that's fo- to reduce high
11          blood pressure=or someth[ing.]
12    Com:                          [ An]d your dizziness.=
13          [One's  f o r  d i z z[y ]ness.]
14    Doc:  [dizziness ( yeah th- [) ]
15    Pat:                        [ O]:h   ]I s  [it? ]
16    Com:                                       [Yes.]
17    Pat:  M:m.
18    Com:  The Ben- er (0.5) Benzofluorid[e, (   )]
19    Pat:                                [I wasn't] aware that I had
20          dizziness. But anyway ((   )).
```

In Extract 7, the companion (patient's wife) added more information about medication to the patient's answer (line 12-13). This line of talk occured after there had been some difficulty displayed by the patient, including the 1.7 second silence at line 08, and the "U:m" (Clark and Fox Tree, 2002) at line 10. This was followed by a pause and a self-repair: "I think that's for- to reduce high blood pressure=or something". The "I think" and "or something" both mitigated the certainty of her answer.

The companion's "oh" at line 09 was both a claim to a change cognitive state (Heritage, 1984) and a possible indication that she had recalled the answer. It is likely that, if the patient had not started his utterance at line 10, she would have continued. The fact that the companion only contributed after a silence is similar to previous extracts, where the patient was given an opportunity to answer first.

It is possible that the information the companion gave at lines 12-13 was what she was going to say at line 09. She designed the turn to add to the patient's answer by using "and". She then repeated it, adjusting it slightly with "one's for". This left some ambiguity to which medication she was referring to, and extended the answer to medications other than the Betahistine, which was the focus of the doctor's questioning[8].

The companion's answer (line 12) was picked up, in overlap, by the doctor at line 14 (though it is unclear exactly what he said). The patient's "oh is it" (line 15) pushed back against the companion's account because it treated as new information something that the patient would know about already (dizziness). This challenging nature became more explicit later at lines 19-20: "I wasn't aware I had dizziness but anyway".

While the patient challenged the companion's contribution, this extract is an example of the companion adding something to a patient's answer. While the turn is designed to look like it is adding information specific to the question, it is actually slipping in information about another drug, and a symptom that the patient has.

[8] It is subsequently corrected from Betahistine to Benzofluride.

In the following extract, on seeing the patient is having difficulty listing medication, the companion contributes by completing it for them.

Extract 8. [184: Spouse: 4.12-5.35](Paracetamol)

```
01    Doc:  We: do see people that ha:ve (0.6) one seizure (0.4)>for
02          no good reason< a:nd it never happens again.
03    Pat:  °Yeah.°
04          (0.8)
05    Doc:  I won't be able to predict whether that would be your
06          case at this moment in ti:me=
07    Pat:  =°mmhmm°
08    Doc:  But you've already gon::e two months
09    Pat:  Yeah.
10    Doc:  Without reoccurren[ce.
11    Pat:                    [But when I was e:r= when I was in the
12          A & E they did sa:y it might have been due to the tablets
13          that I was taking.
14    Doc:  What were you taking at the time?
15    Pat:  Er I was on: (0.6) Tramadol Hydrochloride: [u : m]:=
16    Doc:                                             [Yeah.]
17    Pat:  =Amitriptyline (0.8) Diclofenac a::n[d ]
18    Com:                                      [Pa]racetamol.
19    Pat:  Paracetamol.
```

Extract 8 is similar to previous extracts, with companion offering "Paracetamol" on line 18 as an addition to the list the patient was building. The patient's extended "A::nd" indicated a word search (Clark and Fox Tree, 2002), which recruited the companion to make this addition. The patient's repeat of "Paracetamol" (line19) was a confirmation that took ownership of the companion's addition, putting it "on record" as part of the patient's answer.

2.4 Independently introducing information about medication.

Companions sometimes provide additional information about medication that has not been specifically or explicitly asked for. In the following case, an extended version of extract 8, the companion oriented to what was important in the doctor's line of questioning by offering information about the medication. This had not been asked, but was something that she regarded as relevant.

The context of the list in extract 8 was that that the patient had brought up the possibility that their attacks had been caused by medication. The relevance of the drug list was thus how likely they are to be a cause of the attacks. The doctor's response to the medication list displays a sense of delicacy in managing to seek further information from the patient without prematurely attributing or dismissing one of the drugs to be the cause. Extract

9, which continues extract 8, shows how the companion oriented to the possibility of one of the drugs being the cause of the seizure.

Extract 9. [184: Spouse: 4.12-5.34](Paracetamol)

```
01    Doc:  We: do see people that ha:ve (0.6) one seizure (0.4)>for
02          no good reason< a:nd it never happens again.
03    Pat:  °Yeah.°
04          (0.8)
05    Doc:  I won't be able to predict whether that would be your
06          case at this moment in ti:me=
07    Pat:  =°mmhmm°
08    Doc:  But you've already gon::e two months
09    Pat:  Yeah.
10    Doc:  Without reoccurren[ce.
11    Pat:                    [But when I was e:r= when I was in the
12          A & E they did sa:y it might have been due to the tablets
13          that I was taking.
14    Doc:  What were you taking at the time?
15    Pat:  Er I was on: (0.6) Tramadol Hydrochloride: [u : m]:=
16    Doc:                                             [Yeah.]
17    Pat:  =Amitriptyline (0.8) Diclofenac a::n[d ]
18    Com:                                      [Pa]racetamol.
19    Pat:  Paracetamol.
20          (1.8)
21    Doc:  Difficult to say >I mean< you were we:ll. You you were
22          just sitting ther:e >i- I mean< they could a:ll um both
23          Tramado:l and Amitriptyli:ne (1.9) what else did you
24          say, Paracetamo:[l]
25    Pat:                  [P]aracetamol and Diclofenac.
26    Com:  >I mean <it did happen about an hour after he'd taken the
27          Tramadol (0.5) so.
28          (2.2) ((doctor writing))
29    Doc:  And certainly if people have epilepsy we we ask them to
30          avoi:d Tramado:l >although< often you know we find they
31          are on Tramadol and it's worth stopping so
32           .h[h  ]it's possib[le] [Bu:t-   ]
33    Pat:     [mm ]           [Mm] [>I mean<]I'm not taking any of
34          those no:w
35          [it's only since I've had the operation so.]
36    Doc:  [I'd   just-     I-   I     t h i n k     po]ssibly (0.2)
37          avoid Tramadol in future,
38    Pat:  Yeah,
```

The doctor signalled that his response would be more complex than a confirmation or denial, and that a longer answer would be forthcoming, by framing his turn at line 21 with "it's difficult to say" after a 1.8 second silence. This indicated some difficulty in confirming which drug may have caused the seizure. His account first gave some evidence for the theory the patient had presented (e.g. "you were just sitting there") which implied there is no apparent other cause, and then alluded to the possibility that the drugs might be the cause ("I mean they could all um, both Tramadol and Amitriptyline what else did you say, paracetamol and..?"). By not confirming what caused the seizure, the doctor distanced himself from having to make

a claim one way or the other. Instead, he went on to ask again what medication the patient was taking (lines 23-24).

At lines 26 to 27, the companion (the patient's wife) oriented to the implication that one of the drugs *might* be the cause of the seizures by giving an account that provided more evidence for it being so. She used the space after the patient had described explained again what medication she was onto offer evidence for this implication: "I mean it [the attack] did happen about an hour after he'd taken the Tramadol, so." Her turn was not directly related to either the question asked by the doctor or the patient's answer. Instead, it was in relation to the doctor's earlier account of not knowing if the medication is the cause or not.

The companion's turn was formulated delicately. She did not explicitly say that Tramadol could have caused the attack, or that the timing of when the patient took the medication about their attack is evidence. She did imply this, however, by phrasing it as an independent observation of the timeline of what happened. The "so" on the end of the turn also indicated that there was an inference to be made, although the companion did not explicitly make it. It was a common-sense inference, suggesting that the temporal proximity of the seizure to the taking of Tramadol (coming only an hour afterwards) might mean that the two are related.

This extract illustrates a companion independently adding information to a patient's responses. Unlike previous subsections, where the companion's response arises from the patient's difficulty answering, here the companion's response was an uninvited interjection, providing evidence that Tramadol might be the culprit. Common-sense evidence is often used like this by companions to propose theories or advice in the consultation. However, they orient to the fact that they have less epistemic right to claim cause or offer advice in these consultations than the doctors (Lindström & Weatherall, 2015; Peräkylä, 2002)[9] and may, as in this case, stop short of actually claiming causation.

In some cases, the companion introduced the subject of medication independently within talk on different subject. In the following extract, for example, the companion introduced the subject of medication in an answer about whether the attacks had changed or not. This extract is evidence of the companion orienting to medication as related and important to the current question.

[9] Both these papers focus on patient-doctor interaction as opposed to three party interaction, but discuss the orientation to doctor's expertise .

Extract 10 [167: Spouse: 2.45-4.19] (She's been on medication)

```
01    Doc:  And have the attacks changed since then or are they still
02          the same?
03    Pat:  U::m (1.3) I don't- ((looks at companion))
04          (1.2)
05    Com:  Sometimes when she's been on some medication .hh er
06          she's been prescribed like u:m antibiotics >for instance<
07          she can have six seizures from one session.[ A]nd she can
08    Doc:                                             [Mm]
09    Com:  b:e like nearly unconscious (1.1) but e:r (0.5) a good
10          day is when er she has um (0.6) °just° a normal seizure
11          (0.5) er that's um she's er (0.6) sometimes she don't
12          have a seizure, but er she has headaches and tiredness
13          (0.6) lethargic,
14    Doc:  Mm, So even on a good day this happens?
15    Com:  °Yeah.° (2.7) I don't know if it's down to
16          epilepsy being all lethargic b[ut  H e h }heh heh h[ehh]
17    Com:                                [hhm hhm hu]
18    Doc:                                                   [So:]
19          you say taking anti- antibiotics and being ill can
20          trigger s:ei[zures?   Anyth]ing else?
21    Com:              [Triggers yeah.]
```

In extract 10, the patient had difficulty answering the doctor's question about whether the attacks have changed, which created an opportunity for the companion to contribute. Following a similar pattern seen in section 2.1, the patient recruited the companion by displaying difficulty (line 03, using gaze an extended "u::m", and a cut-off utterance that looks like it might have been something like "I don't know") in answering the question. There was a 1.2 second silence after this in which the patient could have restarted her turn and continue her answer. As in the extracts in section 2.1, it was after this silence that the companion offered an answer for the patient. The slight difference, in this case, is that the doctor's question was not centered around medication, but the companion still brought in medication in his answer. The design of his answer did not directly give an assessment on whether the attacks have changed. Instead, it provided an account of the attacks and the conditions she attributed to them happening more regularly.

While formulated as an observation, the companion's contribution implicitly suggested a link or association between the medication and "six seizures from one session". At first he introduced the medication as a possible factor ("Sometimes when she has been on some medication", line 05). This turn framed the event as special to that condition. He then gave an example of antibiotics ("for instance"), thereby leaving open the possibility that this is just an example and it could be other drugs. He then went on to describe the patient as having had six seizures in one session, which resulted in the patient being "nearly unconscious".

The companion did not explicitly say that this number is more or less frequent. Instead, he contrasted it with an account of what is a “good day”. This immediately indicated the “times when she was on medication” as being the “worst” end of the scale. In describing the contrasting “good day”, he described it as “just a normal seizure”, making the others “not normal” in contrast. He also groups these “just normal seizures” with times she just had other symptoms like tiredness or headaches. While the implication of this comparison between “normal” seizures and seizures when the patient is prescribed antibiotics was left unsaid, the patient’s seizures being worse “when she is prescribed something” allows for a common-sense inference to be drawn that the latter causes the former.

The doctor did indeed make this inference explicit at lines 18-20 (“So you say taking antibiotics and being ill can trigger seizures?”), The companion confirmed at line 21 (“Triggers yeah.”). This is an example of the companion introducing medication as part of an implied judgement about what might be triggering the seizures.

These extracts show three instances where companions offer information about medication during history-taking. In the first (section 2.1), the companions were expressly invited to provide information on the patient’s medical history. In the the second (section 2.2 and 3.2), the companions oriented to the patients’ difficulty in answering a question, or inadequacies in the patient’s answer. In the third (section 2.4), where the companions introduced the subject of medication in a way that drew a common-sense link between medication and the current line of questioning.

However, history-taking is not the only phase of the consultation in which companions use evidential accounts and common-sense logic to push for their theories or recommendations about the patient’s diagnosis or treatment. As we shall see in the next section, it is also one of the ways in which companions can display their opinion at the end of a consultation, when treatment options are being decided.

3 Companions initiatives in treatment decision phase

In history-taking, companions display knowledge about the patient’s medication, This can be a resource for both the patient and the doctor. However, the source of the companion’s knowledge -their close relationship to the patient, which often makes them witness to, and perhaps participatory in, their taking of the medication - also gives them a stake in the decisions about treatment. Since the patient is still seen as the principal decision maker, however, and the doctor is still seen as the medical authority, their role in decision making is, regardless of their stake, secondary.

Much like the companion's role as a witness to medication was revealed in how they contribute in history-taking, the companion's role in decision-making is revealed in the way they contribute to talk about medication decisions in the later part of the consultation. In these cases, the position that the companion formulates or takes is contingent on what has directly come before it. Their contributions often push for or against a particular decision. This does not mean that the companion is pushy or agenda-driven, it does mean, though, that companions can use the space at the end of the consultation to either facilitate discussion, or to resist certain aspects of the decision-making. Post-diagnosis is a normative time for discussion of future medication to be reintroduced, and the companion is often active in these discussions, both about medication and about diagnosis and care.

Like with acting as a witness, the companion can facilitate doctor-patient interactions as a surrogate when the patient is unable or unwilling to answer for themselves. This includes initiating more extensive discussion on medication. Companions also manage their right to take the initiative in the way that they form their turns of talk, using language that frames them as part of the consultation (e.g using pronouns like "we" and "us") while still orientating to the patient's primary rights to knowledge and decision-making.

In the following extract the companion used prompting the patient to ask questions to reintroduce discussions about the patient's treatment and its side-effects. Just before this extract starts, the neurologist (Doc) has been explaining scans of the patient's brain. This explanation has mostly been directed at the patient's father (Com). Due to length, Extract 11 has been broken up into smaller parts for analysis. A complete transcript can be found in the Appendix B.

Extract 11 Part 1. [156: Parent:27.07] (Anything else you want to ask?)

```
Doc:  I Mean there ar:e=>its just< a couple of minor
      abnormalities in the brain as we:ll, there's this little
      dot her:e.
Com:  Mm hmm.
Doc:  Which is a tiny little abnormal blood vessel. .hh There's
      another one back he-°owh° (0.5) there's another back
      he:re.
Com:  Mm hmm.
      (0.5)
Doc:  E::r these are called cavernomas. um and I I think um
      they're probably just coincidental=There's another one
      the:re.
Com:  Mhm.
      (2.2)
Doc:  I would be surprised if they were relevant.
Com:  Right.
Doc:  But it's not impossible.
```

```
18    Com:  Right. .hh Would that suggest-I mean obviously g- >you
19          know< given our experience with with Luke ((Patient))
20          and the Madeloblastoma and and everything=obviously we're
21          sort of quite sensitive to .hh the possibilities of other
22          things developing.=So is that something that would need
23          monitoring o:r?
24    Doc:  Er No cavernomas a:re quite common in a e:r in ordinary:
25          healthy individuals.
26    Com:  Mhmm.
27    Doc:  a:h The only time you would get interested in them is if
28          the:y u:m seemed to be associated with epilepsy. .hh U:m
29          the:y a:re not tumours they're no[t t]hey don't=
30    Com:                                   [N o]
31    Doc:  =have any potential for growth.
32    Com:  Yeah.
33    Doc:  But u:m they can be a nuisance some- sometimes.
34    Com:  Yeah.
35    Doc:  Just occasionally they can bleed=for example.
36    Com:  Mm hmm.
37    Doc:  Cos they- the:y a:re just rather thin-wa:lled blood
38          vessels. [U:m  ]
39    Com:           [Mm hm]m (0.6) It couldn't lead to mini-strokes
40          or anything like that? [(   )]
41    Doc:                         [U::m ] hhh I- those aren't going
42          to cause any problems.
43    Com:  No °no.°
44    Doc:  They're too small t[o (be)] of of significance
45    Com:                    [Yeah. ]
46    Com:  Mm hmm.
47          (1.9)
48    Com:  °mhm°
49          (0.7)
50    Pat:  O[k a  y  ] yeah,
51    Com:   [anything]
52    Com:  anything else (.) you feel you want to ask
53          Luke?
```

At the beginning of this extract, the neurologist was showing the patient's brain scans to the patient and companion. This extract occurs towards the end of the diagnosis, at the point where it is merging into treatment. There had already been a discussion about the patient's diagnosis of epileptic seizures, and the doctor had recommended epileptic drugs.

Lines 18-23 and 39-40 are evidence of a proactive stance from the companion. At lines 18-23, for example, the companion showed initiative by seeking further information about the scan on screen. This turn served a dual function in that it also introduced the idea that what was on the scans may warrant further treatment. There was a self-repair at the beginning of the turn, where the companion went from immediately seeking further information ("would that suggest") to accounting for the question: "given our experience with with Luke and the Medulloblastoma and- and everything=obviously we're sort of quite sensitive to .hh the possibilities of other things developing." This account gave the context of his concerns and explained why he was initiating that line of questioning. The design of the

account included him as someone who not only witnessed the patient's experience, but had been part of it (notice, for example, his use of the pronouns "our" and "we", to refer to him and the patient). This design also formed an account for his concern in that it situated him as someone who, due to past experience, would be sensitive to the possibility of something developing.

Aside from all of this, it also initiated discussion about whether the patient needed to be monitored for the abnormal blood vessels. This initiation was performed indirectly via the action of seeking information about the blood vessels more generally, while also voicing concern about the possibility of what is on the scan developing into something else.

The "things" (line 22) that the companion was concerned about developing were made more explicit at line 39, where the he raised his concern of the cavernomas developing into something like strokes ("it couldn't lead to mini-strokes or anything like that?", lines 39-40). This enquiry came in response to the doctor's explanation at lines 24-37 that what they are looking at is not of great concern, and is in fact "quite common." Notice how the companion formulated his enquiry as a negative interrogative ("it couldn't"), which downplays the assertiveness of it (Heritage, 2002).

The main turn of interest in this extract happened at line 52. This turn, by the companion, came after a 0.7 second silence following the closure of the preceding talk. In this space, either the doctor or the patient could have opened a new topic, but they did not. At line 50 and 51 the patient and companion both begin to speak, but the patient does not continue. At line 52 the companion took the initiative and opened up the interaction again by giving the patient the opportunity to ask any questions that he might have had (or might not have had the chance to ask so far). It was designed broadly, but oriented to the possibility of something having been left unsaid (possibly something the companion knew may be on the patient's mind due to a past discussion). This did, as we can see in parts 2 and 3 of extract 11, initiate a longer sequence

.

Extract 11. Part 2 [156: Parent:27.07] (Anything else you want to ask?)

```
50    Pat:  O[k a  y  ] yeah,
51    Com:   [anything]
52    Com:  anything else (.) you feel you want to ask
53          Luke?
54    Pat:  U::m no no I think that's
55          (0.2)
56    Com:  Do you want to ask a little bit more about the the
57          medication, What what (0.2) cos it's (0.2) >you know<
58          Dr Fuller talked about <sedation> and wh[at-]
```

```
59    Pat:                                          [O:h] yes
60          s[o r r y]
61    Com:   [>Little] bit (Little bit )adverse affects< with the
62          medication as we:ll.
63          (0.7)
64    Pat:  U::m,
65    Doc:  And we talked about feeling a bit [dope]y at high=
66    Pat:                                    [yeah]
67    Doc:  =doses =we talked abou:t ah the rash that you
68          [might (le- le- you)] get an allergic reaction.
69    Pat:  {H m m   y  e  a  h ]
70          (1.2)
71    Com:  Would there be an alternative if Luke found
72          tha[t this-]
73    Doc:     [Lots of] alternatives.
74    Com:  Yeah.
75    Doc:  There are abo[ut  u]m (1.1) ten: alternative=
76    (?):              [(yeh)]
77    Doc:  =anti-epileptic drugs that you could actually try:, (1.0)
78          um and the reason for choosing one rather than another is
79          (0.3) er, really mainly experience.
80    Com:  Mm hmm.
81    Doc:  U:m (0.4) you know what what we fi:nd works best.
82    Com:  Yeah.
83    Doc:  Um so we choose Carbamazepine because it's got a
84          long-term established safety record=which is important
85          because you might be taking it for the rest of your life.
86    Pat:  All right.
87    Doc:  A:nd becau:se it er is effective.
88    Com:  Mm hmm.
89          (0.7)
90    Doc:  Bu:t er if it's not tolerated then there are plenty of
91          alternatives. [So y]ou might try Lamotrigine=
92    Com:                [yeah]
93    Doc:  =instead you might try: um (0.3) Phenytoin instead. (All)
94          those are newer drugs.
95    Com:  Mm.
96          (1.2)
97    Pat:  Okay yeah,
98    Com:  alri:ght?
99          (0.8)
100   Pat:  Fine.
101         (2.0)
```

At lines 52, 56-57 and 61, the companion prompted the patient to ask questions about medication (lines 52, 56-57, and 61). When the patient did not respond to these prompts, the companion took over (71-72). While the companion's initial turns were designed as prompts directed at the patient, the doctor answered them as well, offering a report about the kind of side effects they have already discussed.

The companion's first prompt (line 52) was designed to be open in the sense that the patient could ask anything. It also, however, placed the motivation for asking questions in the patient's domain (eg. "What do you *feel* you *want*."). The use of the patient's first name (Luke) at the end of the turn explicitly recruited the patient to respond, strengthening the

prompting nature of the turn. When the patient declined to take up this opportunity at line 54, the companion pursued the prompt, making it more specific (lines 56-58).

Although the companion was clearly alluding to a concrete, as-yet-undiscussed matter, he held off asking the question for himself. This can be seen particularly clearly at lines 57-58, where he self-repaired from what looks like the beginnings of a candidate question ("What what (0.2)") to instead describing what the doctor has said about sedation (suggesting, of course, that sedation is part of the topic to which he was alluding). That the companion is going to such great lengths to prompt the patient to ask the question, rather than just asking the question himself, shows an orientation to the patient's primary rights to ask about matters relevant to his own illness.

The patient acknowledged the companion's suggestion at lines 59-60. The patient's apology ("Oh yes, sorry") may be evidence of the companion orienting to that the question as something that the patient may have been meaning to ask but forgotten. As Heritage (1984) notes, "Oh" can be a claim of change in cognitive state token that indicates remembering. The patient's turn was nearly in complete overlap as that of the companion, in line 61. The companion continued to prompt the patient, specifying that he should be ask about adverse affects. Over the course of this extract, then, it became increasingly clear that the companion was pushing specifically for this topic to be discussed.

However, the patient continued to display difficulty, in a similar way to what we saw in previous sections (section 2.1 and 2.2), in actually asking the question. The evidence for this difficulty is the "U::m" on line 64 (Clark and Fox Tree, 2002) and the preceding silence on line 63. The doctor's response at line 65 was designed as a summary of what they have covered. It was prefaced with an "and" to attach it to the companion's turn at line 61-62 ("and we talked about…."). This reply in effect answered the companion's prompt, but did so in a way that suggested they have already covered it. The patient answered minimally (line 69) in agreement.

After a further silence (of 1.2 seconds) in which the patient did not take up the prompt to ask questions (further evidence of difficulty), the companion finally asked them directly: "Would there be an alternative if Luke found that this?" (line 71-72). This turn was designed differently to the previous turns, as it was asked directly to the doctor, referring to the patient in the third-person. There is some evidence that the doctor's reply (lines 75-79 and 83-86) was slightly defensive since at this stage the decision about medication appears to have already been made. This was particularly apparent at lines 83-86, where he addressed this idea of a decision about which drug they were going to use: "and the <u>rea</u>son for choosing one

rather than another is 0.3) er, really mainly experience. U:m (0.4) you know what what we fi:nd works best." The pronoun "we" seems to be a professional we, as he then accounted for the choice of this drug by saying it had history of being safe. This account resisted the companion's pursuit of reopening discussions about medication decisions by alluding to the neurologist's professional knowledge about the medication. It also, though, aimed to put to rest the companion's concern about side effects.

The companion's project of reopening the decision about medication was pursued again in the part 3 of extract 11. After the doctor had completed an explanation of side effects, he concluded with "so as I say the most important thing is how you use it". He then went on to indicate how many tablets he would instruct "them"[10] to give the patient. The doctor's turn (in lines 106-108) again attempted to close the interaction. There was a silence of 2.4 before the companion asked the patient for his feelings on this decision.

Extract 11. Part 3 [156: Parent:27.07] (Anything else you want to ask?)

```
102   Doc:  So >as I say< the most important thi:ng is (0.4)
103         ho:w you use it (0.2) It co:mes in 200mg tablets,
104   Pat:  Mm hmm.
105         (1.8)
106   Doc:  Um, and I'll ask them to give you sixty to
107         start off with? (2.6) and I will write down some
108         instructions.
109   Pat:  Right.
110         (2.4)
111   Com:  How do you feel about taking the medication
112         Luke?
113   Pat:  F(h)ine.
114   Com:  Yeah? Okay,
115                (0.5)
116   Pat:  Yea:h_ (0.6) It's what I do anyway, so:. Hhm [heh hhm]
117   Com:                                               [Ha  hhm]
118         (0.6) hhm [hh]m
119   Pat:            [h[hm]  [heh]
120   Doc:              [°y]e:[s° ] °°right.°°
121         (7.4)
122   Com:  Is there a common level at which people begin to
123         experience sedation o:r,
124         (0.3)
125   Doc:  No::,=it's- so much dependent on your metabolism and
126         your size.
127   Com:  Mm.
128   Doc:  And I can't guess what you will experience (0.4) um
129         Luke um (0.8) you might be: extraordinarily
130         sensitive to the drugs=
```

[10] "them" is an outside party, It is ambiguous who "them" is referring to exactly, but from context, the people the patient will receive his medication from.

Having settled the matter of the medication dosage, the companion turned to the patient for confirmation that he understood and was on board with the medication choice (line 111). The 'open' question design elicited the patient's opinions about the medication. The patient's answer at line 113 ("fine") was minimal, but nonetheless confirmed that he was okay with the medication. The companion, however, treated this as not quite enough: "yeah? Okay"(line 114). This prompted the patient to offer a stronger and more extended confirmation at line 116, giving a *reason* for him being fine with the decision ("Its what I do anyway.,").

Despite the patient having confirmed that he was fine, the companion continued to pursue information about the medication's side effects. Following the patient's turn at line 116, and the subsequent laughter, there was a long silence (7.4 seconds, line 121). It was during this silence that the companion self-selected and turned to the doctor to raise a further concern (sedation) about the medication (line 122).

While he was an active participant in extract 11 parts 2 and 3, the companion still treated the patient as principal respondent. This was most apparent in the way that he at first prompted the patient to ask questions, only going on to ask them himself when the patient made it clear that he was unable or unwilling to do so. This extract shows, therefore, the companion seeking information about medication in such a way that treated the patient as the principal decision-maker. This is similar to section 2, where the companions' contributions occurred mainly after evident patient difficulty.

The companion's role in these cases was, therefore, to facilitate conversation and raise medical concerns, where a patient is unable or unwilling to provide a response, thereby acting as a surrogate for the patient. The companion acted in a way that facilitated raising these concerns, having given the patient several opportunities to do so himself.

In the following extract the companion took the initiative to bring up a question about medication, by adding it to the doctor's talk about what happens next.

Extract 12. [169: Spouse: 30.53-34.05] (And in the meantime do you recommend that we continue with his medication)

```
01    Doc:  And I'll get the records u:m (0.9) from ((hospital name)).
02          (0.8)
03    Pat:  Yeah, [and ((             ) ]
04    Doc:        [and from ((hospital ]name)).
05    Com:  And and in the mea:ntime do you recommend that we
06          continue with hi:s (0.2) medication that ((doctor name))
07          =she_did ask us to a:sk um if you recommend that we
08          continue with the medication.
09    Doc:  That's on the basis that this could be migraine[e u[]:m.]
10    Com:   [Yeah.[]
```

```
11    Pat:          [Yea]::h that's what ((doctor nam[e)) said.]
12    Com:                                            [She's gon]:e
13          [d-]
14    Pat:  [((]Doctor na[me)) said
15    Com:                [She said ] there's this Amitriptyli:ne.
16    Doc:  I think the Amitriptyline is [not a ba:d] a bad drug.
17    Pat:                               [(        )]
18    Doc:  It has a number of effects it it can #er# reduce anxiety:
19          it um helps with slee:p um >it can help with migraine.<
20          Um: (3.1) this is odd for migraine (0.6) um[:.]
21    Com:                                                [th]is is what
22          I've said but but (.)[(     )   said   it  is   poss]ible.
21    Pat:                       [doctor from ((hospital name.))]
```

Like extract 11, extract 12 occurred at a point when the consultation was winding down. The companion took the opportunity, at this point, to raise what she was going to do in the meantime about medication (lines 05-08). Her turn is latched onto the doctor's statement and prefaced with "And", thereby designing it to be a 'natural' item in the sequence of 'what comes next' on the 'agenda' (Heritage & Sorjonen, 1994).

Her turn (lines 05-08) is formatted as a question "Do you recommend that we continue with his medication that ((doctor name))" . Although this turn was left unfinished, it was by this point clear that the companion was referring to what this other doctor prescribed or suggested. The companion restarted with an account for this question by explaining the doctor asked them to ask: "she did ask us to a:sk um if you recommend that we continue with the medication." The companion's pronoun "us" included herself as part of the ones whom the doctor had asked, thus justifying her speaking on behalf of the patient. She did, in other words, situate herself as part of a joint decision-making 'unit' alongside the patient.

The companion's question here was managing something quite delicate. She was asking whether the patient should continue taking this medication, but in a way that oriented to the authority of the neurologist. She did this both by phrasing it as "do you recommend", and by adding that the other doctor had suggested asking for this recommendation. This excerpt is another case, then, of a companion taking the initiative to make sure that topics they treat as important are covered.

Another example of the companion taking the initiative can be seen in extract 13. This extract occurred near the end of the consultation, as the neurologist was talking about adjusting the patient's medication in order to avoid the side effects that it appeared to be causing. Again, owing to its length, extract 13 is presented in parts (for the extract in full, see Appendix C)

Extract 13 part 1. [080 : Wife and Son: 6.42](I give him them at night-time)

```
Com1= Wife
Com2= Son.

Pat:   [(      on ).]
Doc:   [So you    We]nt on Keppra, (0.7) At two-fifty twice a
       da:y (0.7) and felt drunk. (2.0) You're no:w on just two-
       fifty milligra:ms dai:ly. And is that making you sleepy?
       (0.8)
Com1:  I g[ive him them at ni:ght-ti:me.]
Pat:      [I   c a n -  I   c a n   slee]p all right=don't I?
       (0.8)
Com1:  Someti(h)mes.
       (1.2)
Doc:   But probably it's not- But you've had a recent attack
       >haven't you?< So it's probably not doing enough really.
Pat:   (No.)
Doc:   °tch.° Okay, Well I would suggest that we u:m change it
       to some other medication.
Pat:   Mm.
       (0.3)
Doc:   U:m and see how you get on with that.
Pat:   Yeah.
Com1:  °(yeah)°
       (1.7)
Doc:   So I'll, I think we'll swap you to: Lamotrigine which
       should be well tolerated.
       (1.7)
Com2:  We- >we did actually< mention that to er <((doctor's
       name))>,
Doc:   Yeah.
Com2:  Y- y- you know. An an alternative to thee (0.2) er the
       one that (0.2) er made him feel drunk.
Doc:   ((Sneezes)) Excuse me:,
       (0.2)
Pat:   Lower dosage [(      )]
Doc:                [ Yea::h ] I thin[k I thi]nk he >I mean<=
(  ):                               [ hmm::.]
Doc:   =I'm su:re he's right in waiting for what we have to say:.
Com2:  >Yeah ye[ah<]
Com1:          [>Tha]t that's what he's saying< he says he'd
       ra:the:r it come fro[m you.
Doc:                       [I I >you know< he'd go:ne a a a step
       further than most GP's in ringing us and
       w[orking out where t]o start.
Com2:   [Yeah, yeah.]
Doc:   >I mean< it's unfortunate that Keppra didn't suit you cos
       it does suit most people.
Pat:   Ye[ah, ] ye[ah.
Com2:    [mhmm]   [
Doc:              [An]d that's just unfortunate really:.
       [ So     um ] I think u:m >you know< I entirely=
(Pat):[ yeah yeah,]
Doc:   = understand where he's coming f[rom.]
Com2:                                  [>Yea]:h yeah<
Doc:   He he he'd done the job really:.
```

There are two companions present in extract 13. The first (Com1) is the patient's wife[11], and the second (Com2) is the patient's son.

The main focus of this extract is lines 25-25 and lines 28-29, where the patient's son agreed with the proposed action on his behalf. The doctor's summary of his recommendation prior to this at line 22 was directed towards the patient, as evidenced by his pronoun use. The patient, however, did not respond. Instead, he left a 1.7 second silence at line 24 (indicative of difficulty) before Com2 responded for him at lines 25-26: "We- >we did actually< mention that to er <((doctor's name))>,". Through the placement of his response, Com2 agreed with the doctor's recommendation, but in a way that indicated this was something that they had asked for before. It conveyed previous knowledge and expectations that this should be the case by constructing it as an independent opinion they already had (and, indeed, had expressed to another doctor previously). The use of "we did actually" constructs this as something that may be news to the doctor and may in fact be contrary to his expectations. As in previous extracts, "we" is used to convey that it was their experience alongside the patient. The turn is also an embedded complaint against the other doctor, and signals to the current one that this solution is one they have asked for and possibly came into the consultation expecting.

The neurologist continued to explain the recommendation (an alternative to the one that "made him feel drunk"), before going on to treat Com2's turn as a complaint. He responded with an account in defence of the other doctor's hesitance (lines 33-35). This was hedged with epistemic markers like "I am sure" and "I think" before supporting the other doctor's decision to wait for a specialist's opinion. Both companions responded, Com2 with an acknowledgement ("yeah yeah", line 36) and Com1 with a more extended turn that is also more aligned with the doctor (line 37-38). She supported the doctor's assessment by confirming more elaborately that the previous doctor had given the same reasoning.

The doctor continued addressing the complaint (lines 39-52), giving his opinion that the GP went "a step further than most GP's". This account of the GP's actions is acknowledged by both Com2 (lines 42, 46, and 51) and by the patient (line 45). The neurologist concludes his defence of the GP at lines 48 and 49: ("I entirely understand where he's coming from, he's done the job really". This is responded to by Com2, at line 51, with a

[11] At the beginning of this extract, there was another instance of a companion (the patient's wife) interceding (lines 06 and 09) after a patient had displayed difficulty in answering (lines 05, and 07). The features that indicate this difficulty, similar to the ones discussed in section 2.1, include the pauses and the patient's recruitment using a tag question (line 07).

double “yeah”. This brings to a close discussion about the GP, at which point Com2 begins to ask further questions about the new drug.

Extract 13 part 2 [080 : Wife and Son: 6.42](I give him them at night-time)

```
Com2:                                  [>Yea]:h yeah<
Doc:  He he he’d done the job really:.
Com2: So the the the ne:w drug that you’re er
       [once you’]ve prescribed.
Doc:   [  Yeah.  ]
Com2: What e:r side effects should we be looking for?
Doc: U:m. It’s normally fairly well tolerated,
Com2: Right.
Doc:  When you first start it, there’s a: risk of rashes,
Com2: Ri[ght.]
Doc:    [ So ] we’ll start things off slowly and build it up.
Com2: Mm hmm.
Doc:  U::m .hhh Headache:s tummy upsets u::m (0.6) sleepiness
      is less common with it,
      (0.2)
Com2: Right.
Doc:  Sometimes on the higher doses in fact it causes problems
      with sleep rather than sleep>but I mean< with any of them
      you can get sleepiness, but it’s [mu-] it’s less likely.
Com2:                                  [( )]
Com2: Yeah<.
Doc:  So those are the sort of thi:ngs um are the are most
      common.
Com2: Yeah<.
      (2.7)
Doc:  With any of our tablets, they’re not addictive. So if
      they cause problems you drop them back down again.
      (17.4) (( doctor writing))
Doc:  So over the next um (.) eight weeks I want you to
      increase it to a hundred milligrams and we’ll see where
      we get to with that.
Pat:  #mm
Doc:  U::m (8.8) .hh Now do you have any questions at all?
      (1.8)
Pat:  >Have any< what=questions?
Doc:  Yeah<.
      (0.7)
Pat:  No not really.
      (4.3)
Doc:  When you went in in u:m December did they c- repeat your
      sca:n?
      (0.8)
Com1: Er yes they did.
      (0.7)
Doc:  I’ll get a copy of that.=And they said there was no:
      other changes?
Com2: No.
Doc:  Fine. Okay so that’s a pla:n for you:. (0.2) So wee:ks
      one and two=twenty fi::ve. Three and four=fifty (.) Five
      and six=seventy fi:ve .hh Eight and ni- ah >seven and
      eight< a hundred,
      (0.4)
Com2: Is is one tablet twenty five grams.
Doc:  Yes.
```

```
105   Com2: Milligrams
106   Doc:  A- as you build up there is a hundred milligram tablet
107         [even]tually:. So u:m (0.4)[ you] can: settle=
108   Com2: [Right.]                   [yeah]
109   Doc:  =on one tablet. (0.4) The seizures have not been very
110         frequent anyway: so I think >you know< let's see how
111         things go:. I-, I'll let your doctor kno:w.=I'll say that
112         if there are any problems give me a ri:ng.
113   Com2: Right.
147   Doc:  (d- you going)to keep that?
148   Com1: Right.[(  )]
149   Doc:        [Now I]'ll give you a prescription for these new
150         tablets. You'll need to pop upstairs for tho:se.
151         (5.1)
152   Com2: S- so this er (.) new drug jus: just to contro:l the: e:r
153         focal seizures.
154   Doc:  Ah And u:m and hopefully the bigger seizure:
155          ([ N e v]er} to recu:r.
156   Com2:   [Right.]
```

The next instance of the companion (Com2) taking the initiative occurs at line 53, following the doctor's summing up in defence of the GP's decision to wait for his opinion. At this point Com2 took the initiative to ask a question which turns the subject back to the new medication: "So the the the ne:w drug that you're er [once you']ve prescribed. What e:r side effects should we be looking for". This turn was 'so' prefaced (Bolden, 2006; Johnson, 2002), linking it to the previous discussion about the medication, and the use of "we" suggested that the companions were involved in monitoring these side effects. The ensuing discussion about the possible side effects they should look out for was mainly between the doctor and Com2. This could be seen in the doctor's body orientation as he was answering between lines 57-81, which was directed towards Com2 (and out of frame). Com2, correspondingly, acted as the recipient of the explanation, as evidenced in him being the one who provided acknowledgements throughout.

The companion also sought information on the patient's behalf about medication. In line 103-105, he asked a question to clarify the doctor's summary of the dosage plan (line 98-101). This kind of question demonstrated that the companion actively sought information, similar to the kind of information companions displayed in section 2. It also displayed the companions' stake in knowing about the patient's medication because they are the ones who managed it. It shows initiative in the consultations for gathering information, not just for future consultations but in order to follow the doctor's instructions. A further example of this is at line 152, where Com2 asked for clarification about what the medication does. He also used a medical term for it ("focal seizures"), displaying a certain specialised knowledge about seizures.

Extract 13 as a whole shows companions pursuing a complaint about the medication that had previously been prescribed to the patient. It illustrated the way in which the companion enacted his involvement in the consultation by including himself in descriptions of previous encounters with physicians, and by displaying, through the complaint, their own knowledge, expectations and frustrations in relation to the patient's seizures. This extract also illustrates how even when the treatment recommendation is aligned with the expectations of the companions and patient, there may be other factors influencing these interactions (e.g. justifying their role in the interaction and their opinions about treatment (medication) decisions).

Extract 14 is another of the companion taking the initiative in response to evidence that the patient had experienced difficulty. In this case, he does so by making a treatment recommendation in response to the doctor's question of what to do next (line 07).

Extract 14 [167: Spouse: 17.39] (Stop taking the tablets)

```
01    Doc:  So what what are we going to do for you? (0.9)
02          You tell me.
03          (0.8)
04    Pat:  I haven't a clue. Heh hah,
05    Doc:  This, this [is l]ike the thi:rd run out=fou:rth=
06    Com:             [(  )]
07    Doc:  [=run out Yeah? so what are we going to do?]
08    Com:  [what ive said, What I've said] is: (0.6) ta- stop taking
09          tablets=and go from there >see what happens.<
10    Pat:  And that-
11    Com:  Cos y[o u    s e e .    ]
12    Pat:       [yeah and what happ]ened the:n? (0.2) I ended up
13          with fits even Wo:rse,
14          (1.0)
15    Com:  >Yeah but< you don't know no:w everything ch[a:n]ges.
16    Pat:                                              [Hhh]
17          (0.6)
18    Doc:  Now (1.0) see: I- I think (0.3) that um: (0.7) these
19          seizures are are very likely to be non-epileptic attacks.
20          (1.4) U::m (0.8) the fact that you've taken tablets for
21          them for so lo:ng is u:m is something that happens to
22          quite a lot of people with non-epileptic attacks. You
23          know, (0.4) they look like > a bit like< epileptic
24          seizures, not everybody who: u:m (0.2) tr- writes out
25          prescriptions is an expert in the treatment of epilepsy,
26          Quite possibly you went to the emergency department at
27          #e:r# ((hospital name)) or ((hospital name) whenever
28          #>you know< er# at first and saw somebody who wasn't
29          really an expe:rt and they thought well it sounds like
30          epilepsy we'll we'll write out a prescription=Then it
31          wasn't working=then they increased the treatment .hhh
32          a:nd quite possibly you never saw an expert at that time,
33          so. There's no evidence you did, you know, there, there
34          is a neurologist comes out to ((hospital name))
35          but [I mean-]
```

```
36    Pat:      [N o   i]t weren't ((beginning of hospital name)) I I
37          didn't see: anyone at ((hospital name)) it was er:
```

In extract 14 the companion made a recommendation about treatment (lines 08-09). Making a recommendation is a delicate thing to manage as the companion navigates avoiding overstepping the traditional roles of the patient as a principal decision maker, and the doctor as the medical authority and therefore more entitled to make treatment recommendations. The companion appealed to common-sense knowledge and their experience as someone involved in the patient's life to make this recommendation.

This extract begins at a point in the consultation where they were going to talk about treatment. The prior talk heavily foreshadowed that they will be moving away from drugs onto other types of treatments due to the diagnosis and the fact that anti-epileptic drugs are ineffective. It was at this point that the doctor asked the patient a question: "So what what are we going to do for you… You tell me."

There was some evidence that the patient was having difficulty in answering this question at line 04. This can be seen in both his laughter, his failure to pick up on what the doctor had foreshadowed in his preceding talk, and him outright stating that he "[hadn't] a clue". At line 08, the companion came in to propose a treatment plan: that the patient should "stop taking tablets" and "see what happens". Making a recommendation like this is, of course, a delicate thing for a companion to do. The companion must, after all, navigate both the patient's right as the principal decision-maker and the doctor's right as the medical authority who is more entitled to make treatment recommendations. In this case, the companion managed this delicacy and made the recommendation by appealing to common-sense knowledge and their experience as someone involved in the patient's life.

The companion prefaced his recommendation with "What I've said is", which suggested that it was something that he had considered and discussed with the patient independently prior to the consultation This also implied, of course, that this recommendation would go against the patient's preferences.

This implication was confirmed by the patient's response at lines 12-13, in which she referred disparagingly to what had happened when she followed this advice in the past : "yeah and what happened then?... I ended up with fits even worse". Beginning this response with a question ("what happened then?") implied that the companion should know what happened, and therefore why his proposal was and should be rejected.

The patient also, in her resistance to the companion's proposal, drew upon a common-sense idea of efficacy (i.e. if stopping the tablets, didn't work in the past why would it work in

the future?). The companion disagreed with this common-sense claim at line 15 ("you don't know now everything changes"), and the doctor supported this disagreement with medical expertise at lines 18-35, explaining at length the likely diagnosis and why not taking tablets would be the right course of action.

In section 3, therefore, we have seen companions using the end of a consultation or topic to initiate talk about concerns about, or suggestions for, treatment. The way that companions initiated and pushed for talk on these matters was designed to manage their right to do so, with a constant underlying orientation to the doctor and the patient having both more established roles in the discussions, and primary rights to knowledge (epistemic authority) and decision-making (deontic authority).

4 Discussion

This chapter has focused on companion's contributions to discussions about patients' medication in the seizure clinic. Like the previous chapter, it works towards the aim of this thesis (to examine the companion's role in the seizure clinic) by shedding light on a specific aspect of the companion role.

The chapter has shown how companions play an active role in medication discussions, both in the history-taking and treatment phases of the consultation. In twenty out of thirty consultations (two thirds), companions contributed to discussions about medication in some way. Their knowledge and activity in these kinds of discussions were not limited to medication. Since medication is a central part of western medicine, however, it should not be a surprise that it was a central concern of the companion as well as the patient.

Overall this chapter demonstrated a high frequency of companion participation in discussions about medication. In their contributions, companions displayed both knowledge about the medication their loved ones took and a stake in the treatment decisions that were made. They were shown to be an informational resource about medication, as well as facilitating decision-making in the treatment recommendation stage by making suggestions, prompting the patient to ask questions, or asking questions themselves.

Section 2 examined how companions contributed to talk about medication in history-taking. In this section, companions tended to be used as an informational resource about medication by patients and doctors. Sometimes, also, companions orientated to a patient's resistance or difficulty in answering about medication and contributed in response. The subsections were organized based on how the companion came to talk, mirroring Chapter 3. However, the focus was on what the companions did when they contributed.

In section 2,1, companions tended to act as a resource for the patient and doctor. Sometimes the companion was selected to contribute to discussions about medication because they were in possession of the list of medication. In other cases, the patient recruited the companion by displaying difficulty through extended “ums” and pauses, and gaze. In section 2.2, the companions were recruited in contexts where the doctor was pursuing an answer from the patient. Here the companion contributed after the patient had shown difficulty or unwillingness in answering a question about medication.

In section 2.3, the companion contributed after the patient’s turn by adding to or adjusting the patient's answer. In these cases, the companion was orientating to a perceived insufficiency in the way the patient answered about medication. In section 2.4, companions independently introduce medication into history-taking discussions. In the cases shown the companions introduced the medication as part of proposing a theory for the cause of the seizures, thus showing how companions can bring up medication when they orient to it as important.

These cases show that the companion’s shared experiences with the patient gives them access to knowledge about the patient’s condition and medication. This knowledge can then be used as an informational resource by both the patient and the doctor. This section particularly shows some ways the companion fulfils their role of offering informational support (Laidsaar-Powell et al., 2013). Through both being an informational resource for the patient and doctor (section 2.1), facilitating information exchanges when there is difficulty or perceived insufficiency (section 2.2-2.4), and independently introducing information, they have knowledge about that they orient to as important (section 2.4). The use of medication lists also shows companions giving informational support by keeping records. In this way, this chapter illustrates what some of the ideas of the role of the companion proposed in other research (Ellingson, 2002; Laidsaar-Powell et al., 2013) look like in interaction.

In section 3, companions were shown to take the initiative to facilitate questions and discussions about treatment at the end of consultations. Their turns often come after the patient has had an opportunity to take the initiative and but has not done so. When the patient has not been given an opportunity, either the doctor or the companion orient to give the opportunity to the patient (see extract 13, where the doctor turns and asks the patient if they have questions, and extract 11, where the companion tries to prompt the patient into answering questions). When the patient does not take this opportunity, the companion can be a surrogate for raising these concerns.

Section 3 shows examples of behaviours Clayman et al.(2005) described as ‘autonomy-related behaviours’ that facilitate decision making. These include asking questions, raising concerns, and prompting the patient. These extracts show that the companion can facilitate decision-making by acting as a surrogate when the patient is unwilling or unable to initiate questions about medication. However, this section also shows that, while these behaviours can facilitate decision making, the companion may show initiative in a way that does not align with the patient, to the point where they are sometimes arguing against the patient. In these cases, they are both facilitating and advocating for the patient, while also revealing their own stake in or opinion about treatment.

Consultations are traditionally thought of as between patient and doctor, and we can see the companion orientate to this dynamic in these extracts. While companions have first-hand knowledge of the patient’s medication and circumstances, the patient has the normative right to answer for themselves if they can and are willing to. When the companion participates in facilitating treatment decisions, and providing informational support, they also have to manage and negotiate their right to participate. The design and placements of their contributions manage their epistemic rights as witnesses while still respecting the normative rights of the patient to answer for themselves, as well as the doctor’s epistemic authority as the expert. Some of the ways the companion displayed orientation to the patient’s rights as primary respondent were in only coming in after the patient had had an opportunity to answer first, and in directing their contribution towards the patient rather than directly at the doctor (which would, of course, be answering for the patient).

Given companions’ orientation patients’ and doctors’ rights as the ‘main’ respondents in the interaction, they often had to justify their participation in the talk. One of the ways in which they did so was to include themselves by using collective pronouns like “we” and “us”. Such pronouns demonstrated their presence during both seizures themselves and earlier consultations, thus justifying both their knowledge and their right to participate. The exceptions to this were cases where it was established, due to context, that the companion was the appropriate primary respondent (e.g. cases where they were in possession of the drug list).

The previous two chapters have looked at how companions can contribute to the medical outcomes of the consultation by providing informational support. In chapter 4, this was by providing an alternative version of the patient’s answer when that answer was minimising or downplaying the symptom severity. In the present chapter, meanwhile, it was through their contributions to discussions about patients’ medications.

Informational support was one of the key aspects of the companion role identified in the literature review at the start of this thesis (Ellingson, 2002; Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Laidsaar-Powell et al., 2013). Another, equally important, aspect of this role identified in that review was emotional support (Ellingson, 2002; Laidsaar-Powell et al., 2013). Emotional support is different from informational support in that it is grounded in the relationship between the companion and the patient, rather than the institutional, medical outcomes of the consultation. It has also been understudied compared to informational support. The final chapter of this analysis will now explore one of the ways in which companions can provide emotional support – by touching patients at delicate or sensitive interactional moments.

CHAPTER 6 SUPPORTIVE TOUCHING DURING DELICATE INTERACTIONAL ENVIRONMENTS

1 Introduction

Most medical consultations are one on one, between a doctor and a patient. In seizure clinics it is more common for a companion to be present (e.g. in 26 out of 48 consultations used for this research there is a companion). This is because the patients are encouraged in a letter to bring a companion with them. One of the reasons for this is that the companion is often someone who has witnessed the patient's seizure and can give a description of what it looked like and what happened when the patient was unconscious.

The features of three party interactions are somewhat different from two party interactions. Multiparty interactions place a bigger strain on turn organisation. The importance of non-verbal cues, including eye gaze, and body turning are more noticeably employed than in two–party interactions (Fukui et al., 2011; Heath & Luff, 2012; Rossano, 2015; Stivers, 2001; Stivers & Rossano, 2010). For example gaze and body turning is often used to select speakers and indicate a person's role in the interaction (Heath & Luff, 2012; Stivers & Rossano, 2010).

Another kind of embodied action is touch. In medical interaction, it does not happen very often, possibly because touching between patient and companion is not a setting relevant behaviour in a clinical (institutional) environment, touch being rather more appropriate in a private setting. When touch happens between patients and companions, they are sitting next to each other or close to each other, as in the image below(Figure 6.1)) In cases where they are not sitting next to each other, the touch becomes a different sort of business because they also have to move closer in order to accomplish it

Figure 6.1 Layout of room in which Touch occurs

In 26 interactions with a companion, there are only 5 cases of touching. Two of these cases occur at the beginning the interaction. The companion puts his arm around the patient, or rests it on the back of her chair. These types of contact look markedly different from the other forms of touching discussed in this chapter, both in action and sequentially. They appear to be a different kind of touch or sequence. The 3 remaining cases stand out because they occur in the midst of the consultation not at the beginning or end. Figure 6.2 is an example of one of them.

Figure 6.2 Companion Touches Patient's hand

The purpose of this chapter is to look closely at these 3 cases and an additional case where a touch seems to be attempted but does not occur and analyse the exact sequential positions in which these are being done, in order to figure out what is going on. What is the companion doing? Does it turn out that these are systematically placed?

From analysing the cases it looks as though they occur in systematic places. These cases can occur in instances when the topic is delicate and the patient is revealing something personal, or vulnerable. The topic being discussed is treated by the participants as awkward, sensitive, or emotionally distressing. The patients are not necessarily revealing things about themselves for the first time, but are revealing it in these interactions for the first time. In some of these cases the talk is also paired with a noticeable display of emotion. Yu & Wu, (2015), who looked at how people talked about delicate and awkward topics on a Chinese medical radio show, emphasised that topics are not inherently delicate, and therefore analysis should focus on how people treat topics as delicate. A similar distinction should be made in this chapter; these touches do not occur because a topic is inherently delicate, but occur in

sequential places where participants are treating the topic as delicate, sensitive or emotionally distressing.

In this chapter, the cases are described in terms of the sequential relevance of the touch, and the emotionality of the patient's turn of talk, and how the participants treat the topic as delicate. That will show the touch seems to be doing an activity in relation, sequentially, to some emotional aspect of the persons talk, but in a way that does not disrupt the project of the "business of the talk".

2 Moments of companions touching during consultation.

In 3 cases there is a similar kind of touch that appears to occur in a similar sequential place; however in the fourth case there is a similar sequential place but the touch does not occur because it is physically and verbally rejected by the patient.

In the first case, the doctor asks the patient if she has seen a psychologist. The design of his turn treats the subject sensitive and the companion touches the patient after she reveals the reason for the counselling, sexual abuse.

Case 1 [162: Spouse: 19.43] (Depression)

```
Doc:    Did=have you (0.4) had any °s-° u:m have you
        seen a psycholo- psychiatrist
        befo[:re this?]
Pat:        [  I    ha]ve yes.
Doc:    And what was that for?
        (0.2)
Pat:    Depression.
Doc:    And how long have you had
        depression fo[r?]
Pat:                 [ S]ince (           )
        (2.8)
Doc:    So y[ou've seen a] psychiatrist for that?
Pat:        [ I've been  ]
Pat:    #Yea:h# been on and off since >as I said<
        being a child.
        (2.8)
Com:    Doctor (( name's)) just start[ing th]is=
Doc:                                 [ mmm, ]
Com:    =E.M.D.R:. really °hasn't he?°
        (1.0)
Doc:    okay
        (2.8)
Doc:    .hhh gm=were there any particular reasons why
        you were depressed in in your childhood or?
        (0.2)
Doc:    °(   [  ) °    °(   )°]
Pat:         [It is coming abo]ut now really=it's kind
        of down tuh (1.6) abuse as a child.
        (0.2)
Doc:    Mmm.
```

```
31    Pat:      °So: yeah.°
32              (3.6)
33    Pat:       |I think it's sort  of
34               com|ing out  no:w more than ever
35                  |Figure 6.4: ((Com places hand on pat's leg ))
36              (1.2)
37    Doc:      #W::#when you say it's coming out more than
38              ever=>what do you mean<.
```

```
(The companion continues to hold his hand on the patient's leg as the
interaction moves on to more routine questions like if she smokes and who
she lives wth. )
```

In these cases, the touch occurs in the middle of a sequence, rather than at the beginning or end of the consultation. It occurs, sequentially, in a place where the patient is revealing a something, that is being treated as delicate by participants. Section 3 of this chapter*; Delicacy as a Sequential Environment.* will discuss how the participants treat this topic as delicate in more depth. The focus in this section is on how the touch is timed with the patient‘s talk.

At lines 23-24, the doctor asks, “were there any particular reasons why you were depressed in in your childhood or?”. The “or” indicates continued orientation to delicacy (Stokoe, 2010). The answer to this question (line 27-34) is the main topic of the environment in which the touch occurs. The patient’s answer (line 27-34) is slightly delayed, causing it to appear in overlap with doctor who says something else. Rather than saying immediately what the reason was, her answer is constructed in a way that delays it further, explaining first “it’s coming about now really,” indicating that the reasons are relevant for her depression now, as they continue to be. The latched “it’s kind of own tuh” downplays or minimises the reason, before a pause and finally “abuse as a child”. The formulation of abuse as a child is impersonal, distancing herself from it. This is followed by a long silence, after which the doctor gives a minimal “hmm”. She then continues with a very quiet “so yeah” which sounds like she is sort of summing up the reason. This is followed by a much longer silence (3.6 seconds) where she touches her face (Figure 6.3 A)

As she begins to move her hand away with her gaze on it (Figure 6.3 B), she repeats what she started her answer saying, “I think it’s sort of coming out now more than ever”. The “sort of” mitigates her utterance. It is at the end of this utterance (line 35), that the companion places a hand on her leg (Figure 6.3 D, Figure 6.4).

The companion’s movement to touch her leg starts just as the patient says “coming”, but is completed by “now”. The companion does not talk throughout the time his hand is placed on the patient’s leg, and the hand placed on her leg is unobtrusive to the verbal sequence, between the doctor and patient. His hand remains on her leg for the rest of the extract, and the questions move on through discussions about her counselling and onto other

history taking. Neither the patient nor the doctor reacts or acknowledges the touch has taken place.

Figure 6.3 timing of the companion's hand movement with the patient's response .

Figure 6.4 The companion places a hand on the patient's leg

There is something significant in the sequence that leads to the companion placing the hand on her leg. In this case it occurs after the patient self-touches and after she has been revealing a particularly difficult, sensitive and emotional topic (treated as such by her and the doctor), that she has linked to her depression in the talk. The touch also occurs at a moment when she is mentioning that this delicate topic is "coming out now more than ever."

The way the topic of talk is treated as delicate is important to understanding the sequential relevance of these touches, as they seem to be in response to the emotional and delicate nature of the talk. The next case involves a similar subject of discussion, in this extract the patient displays emotional distress as she mentions the reason for her counselling was because her daughter told her that her partner was sexually abusing her.

Case 2 [170: Spouse: 15.22] (I don't like to talk about it)

```
Doc:     And what kind of treatment for these
         blackouts?=
Pat:     =Nothing.
         (2.8)
Doc:     No: tablets an n:o=no talking treatments
         either=no counselling.
         (0.8)
Pat:     tch I have cou:nselling but that was just
         throu:gh but not for the
         blackout[s  just  general]
Doc:             [So what was the ]counselling fo[r?]
Pat:                                              [.h]hh
Pat:     Hhhh Just relationship break-ups: and er (3.8)
         sexual abuse basically.
         (0.5)
Doc:     And wa- wa-  when did you have this
         co[unselling?]
Pat:       [No, it  wa]sn't it wasn't >sexually< it was
         e:r (1.8) I'd been with my partner for ten
         yea:rs .hh and me daughter came to me when she
         was f:ourteen and told me that (0.4) me
         partner had bee:n (0.6) sexual abusing her.
Doc:     Mm.
Pat:     So: (0.4) that's why I got the counselling=
         not fo:r (0.4) this.
Doc:     hmm,
         (2.0)
Pat:     Bu:t it were:n't li:ke there were no proof >or
         anything like that< so: (2.0) °that were l-
         that were quite a long time [w e r e n 't    it?°]
Com:                                 [((turn gaze at pat))]
         (0.2)
Doc:     Have you split up from this partner?
Pat:     Oh god yea:h. °haha°
         (2.4)
Pat:     But >he said and she says it's he said< (0.2)
         she didn't she said >he did but I me:an<  .hhh
         (0.4) I dOn't tAlk about that really I just
         keep t[hat] to the bottom=its something I=
Doc:           [Mm.]
Pat:     =don't talk °about°.
Doc:     So when did you have that counselling?
         (1.6)
Pat:     E::h (0.2) after that [after-
Doc:                           [So how lo]ng ago was
         that? ((Doctor looks at notes, touching page))
         (1.4)
(Doc):   °mm:°, (( Doc moves page)) °mm:?°
```

```
59              (2.8)
60    Com:      About three years ago >weren't it?<
61    Pat:      Yeah (0.2) I've had it two or three times.
62              (0.4)
63    Doc:      Mm.
64              (0.4)
65    Pat:      E:r (wa) last one was three years ago.
66              (2.0)
67    Doc:      And wh-why did you have the counselling=what
68              kind of problems did you have=why did why did
69              you (0.2[) ask for it?]
70    Pat:              [I couldn't co]pe I couldn't cope with
71              the::
72              (1.0)
73    Com:      I think something were mentioned and it
74              brought it all back up [didn't it?]
76    Pat:                             [You see YE]:ah what it
77              is i- i-hh .hh  It got mentioned agai:n.
78              (0.2)
79    Pat:      A:nd it brought it all back up=so: i- i- .hh
80              IF I talk about it makes me feel ill. ((Fig. 6.5A))
81    Doc:      Mmm.
82              (2.6)
83    Pat:      ~But that's [not to do with~ tha:t
84    Com:                  [  ((looks   at    Pat))((Fig. 6.5B))
84              (0.6)
85    Pat:      That's not to do with me [°blackouts.°
86    Com:                               [(( unfolds arms))((Fig. 6.5C))
87    Com:      [((strokes Patient's hand))((Fig.6.7)
88    Doc:      [ Mm.
89              (0.6)
90    Pat:      Its something you don't [like to ~talk about.~
91    Com:                              [(( holds Pat's hand, Fig. 6.7))
92              (5.2)
93    Doc:      Other than that you mentioned your
94              gallbladde:r? Have you had any other health
95              problems in the pa:st?
```

A similar contextual environment to that in case 1 occurs here also in case 2. Following the doctor's question about blackouts on line 01-02 the discussion progresses to questions about the patient's counselling. The doctor asks at line 11 what the counselling was for, leading to patient revealing information about the sexual abuse. In this case, the patient also displays emotional distress in the way she talks, e.g. voice breaking (line 83 "~But that's not to do with~ that" and line 90 "you don't like to ~talk about~"; the ~ symbol indicates a wavering quality in the voice). The companion's gaze shifts to the patient as her voice starts to break and unfolds his arms to stroke her hand, turning the stroking into a hold at line 91, after her voice breaks again at line 90, where she repeats that she does not like to talk about it.

The companion is orientating to the patient's emotional distress/difficulty with talking, especially about the topic of her daughter's sexual abuse. He starts to turn his gaze to the patient as her voice starts to waiver, but before he can touch her, he needs to unfold his arms (Figure 6.5). He initially does a stroking movement before moving on to holding her hand.

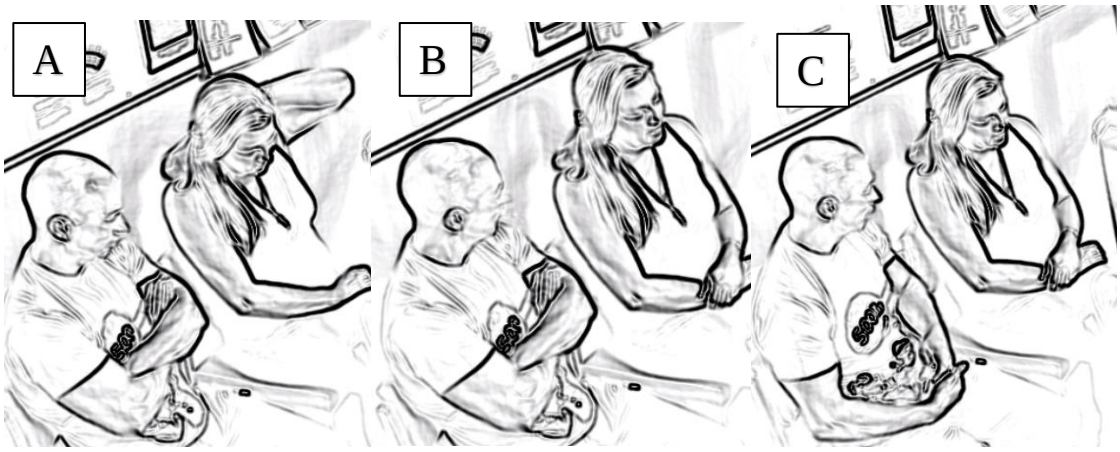

Figure 6.5. Companion unfolds his arms.

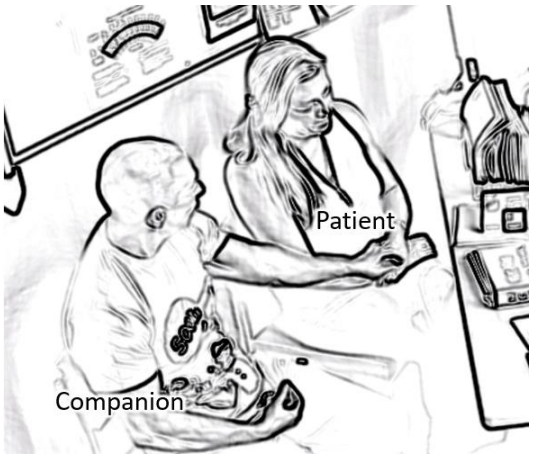

Figure 6.6 Companion strokes patient's hand (line 87)

Figure 6.7 Companion holds patient's hand (line 91)

In the following case is an example of a similar touch occurring with a different topic. The patient is describing his experience of his seizure, when the companion reaches over and hold his hand.

Case 3 [169: Spouse: 0.32] (Funny Feeling)

This extract takes place at the beginning of the interaction. The doctor asks an opening question and the touch occurs during the patient's problem presentation.

```
01    Doc:     What can I do for you:?
02    Pat:     U:m (0.6) <she weren't sure it's u:m>
03             .hhh °i'm trying to° I get a funny
04             [feeling in the back of my neck like a pressure feeling.]
05    Pat:     [((touches back of neck)  (Figure 6.8))                 ]
06    Doc:     Mm hmm,
07    Pat:     And I feel right heavy headed (0.6) and I just lose a:ll
08                (0.5) not so not so much feeling but (0.6) all
09                the strength sucked out
10             [of me and I just drop where I'm standing.
11    Com:     [((lifts arm up to shoulder & adjusts bra (Figure 6.9)))
12             (1.4)
13    Com:     [((Com holds Pats hand ))] ((Figure 6.10))
14.            [         (2.0)          ]
15    Pat:     It started Christmas Da:y.
16             (3.8)
17    Doc:     Christmas Day you were last here?
18    Pat:     Yeah.
19             (1.8)
20    Doc:     So what can you tell me about the fi:rst attack?
21             (0.9)
22    Pat:     A::h we got up (0.2) kids opened all their presents.
23.            (1.5)
24             And ah we had breakfast=I washed the pots.
25    Doc:        Mm hmm.
26    Pat:        A:nd I just went in the roo:m and I felt (0.4) just had
27                this feeling and I just dropped on the sofa.
```

In Case 3 the touch occurs at line 13 in the problem presentation phase of the medical visit, just after the doctor asks the opening question of the session. The patient is describing his experience of his attacks. The description of the attack is violent, with imagery of having the strength sucked out of him and dropping where he stood. The touch occurs after he had described dropping where he was standing, indicating a sudden collapse (line 10). This description is followed by a long silence in which the companion moves, first uncrossing her arms to adjust her bra (Figure 6.9) and then reaching out to hold the patients hand at line 13 (Figure 6.10) The patient is the one who speaks again after the silence to talk more about his attack and the companion also remains silent throughout.

Figure 6.8 Patient touches back of neck (line 05)

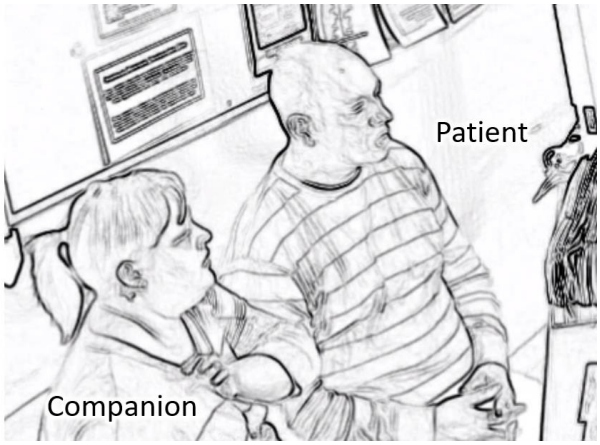

Figure 6.9 Companion lifts arm up to own shoulder & adjusts bra (line 11)

Figure 6.10 Companion holds patient's hand (line 13)

The way the patient describes the attack treats it as delicate. His description suggests difficulty describing his experience, e.g the use of vague terms, like "funny feeling" and "like

a pressure feeling", the "like" indicating that it is an approximate description; other evidence is the repair at line 10, "so not so much feeling but (0.6) " which indicate difficulty describing what happened. Combined with more violent choice of descriptions "strength sucked out" and "I just drop where I am standing," this suggests an experience that is hard to describe but alarming.

The fourth case contrasts with the previous cases. In this example, the companion is further away from the patient; this leads to the companion's monitoring of the patient's emotional state becoming explicit in the talk, and disrupting the current medical discussion, in a way the touches in the previous cases does not. The companion's attempt to touch the patient at a moment of displayed distress is also rejected by the patient. However, even though the touch does not occur, it is similar to previous cases as the attempt or incipient touch occurs at a moment where there is something sensitive/delicate about the topic being discussed.

Case 4 [186: Parent: 09.01] (I'm Fine)

```
01    Doc:     I think that (0.8) does push me towards
02             thinking: (.) these are epileptic attacks,
03             (0.4) >Epileptic attacks< tend to be <very>
04             >stereotyped<.= (They're) the same each
05             ti:me. .hh whereas emotional type attacks
06             tend to gradually change over the yea:rs.
07             (0.2)
08    Doc:     And yours have never changed.
10    Pat:     ((Pat shakes head))
11    Doc:     .hh The other- The other thing which is some
12             evidence, that they're epileptic, is that they
13             do seem to have impro:ved- (0.2) a little bit,
14             (.) at least. with the tegreto:l, >which is<
15             what you'd expect.
16             (0.4)
17    Doc:     .hh Emotional attacks: (0.4) #e::h# there's
18             not usually any (0.4) consistent
19             improvement °with the Tegretol°.
20             (0.6)
21    Doc:     .hh Now th[e obvious approach] (0.4) if you're
22    Pat:               [((looks  to  Com))] ((Figure 6.11))
23    Doc:     getting some response >to the Tegretol< is
24             simply to increase the
25    Doc:     Tegre[tol:, and see if you ]get a better=
26    Com:           [((sits up straight))] ((Figure 6.12))
27    Doc:     =response.
28             (0.2)
39    Pat:     °>yeah<°
30             (0.4)
31    Doc:     .hh Tegretol is a very s:afe (0.6) drug.
32             (0.2)
33    Pat:     Yea[h, I've be]en on them °be°fore?
34    Doc:        [You  don't]
```

```
Doc:    You ca:n't injure yourself >with
Doc:    [Tegretol<.= e]ven if you take-
Com:    [You alright?|]
                     |((Figure 6.13))
        (0.2)
Pat:    yeah?
        (0.2)
Doc:    °you okay?°
        (0.2)
Pat:    °M: hm?°
        (1.2)
Doc:    ((gives Pat tissues))
Pat:    No, it's ~fine?~
Pat:    ((Pat takes a tissue))
Doc:    tk! E- E- Even if you take (you) a- a big uh-
        uh >overdose of Tegretol<.= It doesn't make
        any: (0.4) u- uh it doesn't do you any harm.=
        You've just to wait for it to wear off.
        (0.4)
Pat:    (                  ).
Com:    hh hi ha °ha ha°
Doc:    A- are there- #a-# are <th[e:re]> (0.8) other
Com:                            [hmh!]
Doc:    issues that- that- y- I mean you're obviously
        upset.
        (0.2)
Pat:    (Woh- I- I'm just-) well you're saying t#hat#
        (.) you think they're epileptic, I've just
        always #want#ed to 'ear, .hh #wha#t they could
        be?
Doc:    M:.
        (1.4)
Pat:    So:.(0.4).hh >I just< wanted to have a ~na:me
        for it?
        (0.4)
Doc:    Yeah.
        (0.2)
Doc:    I think it's important?
Doc:    °ye:s.°
Pat:    (ye ).
         [(1.0)
Pat:     [(( puts[ hand on face))
Com:             [ lifts arms and starts to move]
Pat:    I'm [f[in-   [I']m    fi:ne.   ]
Pat:        [(( Looks at com and leans back away from com))
Com:          [huhuhu]
Com:                  [((Com stands up))]((Figure 6.14))
        [((Com sits back down))]
Com:    [Y[ou're]      £fine    ]
Pat:      [I:'m-]
        (6.0)
Doc:    So the approach we would no:rmally adopt i::s:
        (0.2) u::m
```

Figure 6.11 Patient looks at companion (line 22)

As in cases 1-3 the attempt to touch here occurs at a moment where something delicate is being discussed, the diagnosis. It is treated as delicate by the way the doctor designs his lead into, and explanation of the diagnosis. As in previous cases, the doctor's build-up to the topic is drawn out over multiple turns. It appears delicate because of the use of perturbations and pauses. How he designs his delivery is also delicate, he describes being "pushed towards" a diagnosis, and describes the evidence for it in comparison to "emotional type attacks". The patient responds minimally during the explanation. When the patient glances at the companion at line 22, her facial expression which displays upset, becomes visible to the companion. The companion shows a marked increase of attention (by sitting up, gaze focused on the companion at line 26, Figure 6.12) when the patient starts displaying emotion.

Figure 6.12 Companion sits up, gaze focused on companion (line 26)

One thing that is particularly different right from the beginning of the extract is the layout of how the patient and companion are sitting. In cases 1-3 the companions are sitting right next

to the patients (e.g.. Figure 6.1). However, in case 4 the companions are sitting quite a distance away, as can be seen in Figure 6.13

Figure 6.13 Companion asks if Patient is alright (Line 37).

This means that touching each other for any reason becomes difficult and requires movement to get closer. The companion does not immediately reach for or move closer to the patient, but instead interrupts the talk to ask verbally if the patient is all right (line 37). This emotional check makes the patient's emotional state relevant for discussion, by both the companion and the doctor, and disrupts the sequence about the diagnosis and treatment, leading to other embodied actions like the doctor offering tissues (line 45).

Figure 6.14 Com stands up, Pat has leaned away from Com (line 80).

What is interesting is that at line 76 (Figure 6.14), the companion begins to move towards the patient. The patient's reaction to this is to both repeat her response "I'm fine" and move back. This suggests that the patient orients to the companion's movement as linked to the topic of her emotional state, and that the companion intention is to get closer to her. While it is not

possible to know what the companion would have done, if not rejected, some form of touch is a likely possibility

Therefore even though no touch occurs, case 4 is similar to the other cases as it has a similar sequential environment of a delicate topic being discussed and some emotional work happening that the companion is attending to. It also is similar in that the companion makes movements that the patient orientates to intention to get closer.

3 Delicacy as a sequential environment.

Looking across the cases one can observe that the delicacy of the topic of talk is orientated to by the doctor and patient. It is visible in the way that the doctors designs hisquestions, and how the patients answer. In Case 1 the delicacy of the talk can be seen from the opening question at line 01 about whether the patient has seen a psychiatrist.

Case 1 [162: Spouse: 19.43] (Depression)

```
01    Doc:     Did=have you (0.4) had any °s-° u:m have you
02             seen a psycholo- psychiatrist
03             befo[:re this?]
04    Pat:         [  I    ha]ve yes.
05    Doc:     And what was that for?
06             (0.2)
07    Pat:     Depression.
08    Doc:     And how long have you had
09             depression fo[r?]
10    Pat:                  [ S]ince (           )
11             (2.8)
12    Doc:     So y[ou've seen a] psychiatrist for that?
13    Pat:         [ I've been  ]
14    Pat:     #Yea:h# been on and off since >as I said<
15             being a child.
16             (2.8)
17    Com:     Doctor (( name's)) just start[ing th]is=
18    Doc:                                 [ mmm, ]
19    Com:     =E.M.D.R:. really °hasn't he?°
20             (1.0)
21    Doc:     okay
22             (2.8)
23    Doc:     .hhh gm=were there any particular reasons why
24             you were depressed in in your childhood or?
25             (0.2)
26    Doc:     °(   [  ) °    °(   )°]
27    Pat:          [It is coming abo]ut now really=it's kind
28             of down tuh (1.6) abuse as a child.
29             (0.2)
30    Doc:     Mmm.
31    Pat:     °So: yeah.°
32             (3.6)
33    Pat:     I think it's sort  of
34              com[ing out  no:w more than ever
35                 [((Companion places hand on patient's leg ))
```

```
36              (1.2)
37    Doc:      #W::#when you say it's coming out more than
38              ever=>what do you mean<.
39    Pat:      I think because obviously no:w I'm seeing
40              doctor ((name)) it's something I've kept (0.4)
41              hidden °or° to the back of my mi:nd  I don't
42              >(    )< kno:w.
43              (0.4)
44    Pat:      Obviously I'm dealing with it.
45    Doc:      Mmm.
46    Pat:      But it's obviously coming to the fo:refront.
47              (4.4)
48    Pat:      Whether that's cau:sed from: (0.2) I: >don't
49              know depression< it's sort of easy tuh kind of
50              blame something >I don't know,<
51              (2.5)
52    Doc:      How often do you see doctor ((name))?
```

The doctor orients to his opening question in line 1 as needing to be broached delicately. The turn has three self-repairs where the doctor reformulates the turn. From "did…" which is cut off to "have you had any s-". This is then changed to "have you seen a psychologist". Other features that mark this is as being treated as delicate are the pauses and "ums" in the turn.

Features of the patient's response also mark that they orient to the topic as delicate. Her response at line 04 is minimal. This is in marked comparison to other instances in the talk where questions about previous visits to health professionals are commonly answered by a small account of when, what was wrong and how they were treated (if possible). She does not go immediately into detail about the psychiatrist, or why she has seen one. Instead, the information about her psychiatric medical history is drawn out over a series of turns, with questions from the doctor and unexpanded, minimal answers from the patient. (e.g. line 07. "Depression" and later "since, as I said, being a child"). In this way the patient is revealing only the minimum in order to answer the doctor.

As the extract continues, the doctor's question covers even more personal ground. This question leads to the main sequence that the touch occurs in. At line 23, he asks the reason for her depression, hereby orientating to the significance of the previous answer "since childhood" and including that in his question design. ".hhh gm=were there any particular reasons why you were depressed in in your childhood or?" This is designed to manage the delicacy both because it is negatively valenced "any particular," leaving room for the patient to say there wasn't, in part through the trail-off "or?" (Stokoe, 2010).

There is a slight silence before both the patient and the doctor come in overlap. (doctor line 26, patient line 27). This like other silences may be another marker that there is something delicate going on, especially taken in the context of the delicately designed turns and the patient's minimal answers.

The design of the patient's answer (line 27) also marks the delicacy of what she is revealing. "[It is coming about now really=it's kind of down tuh (1.6) abuse as a child." The answer to "reasons for her depression" is delayed until the end of the turn. This is done with hedging "it's coming about now really", mitigation "kind of down tuh" and a long silence (1.6) right before she reveals "abuse as a child". In talking about the abuse, she omits stating a subject of the abuse (it is not "I was abused as a child", but "abuse"as a noun). By doing this she distances herself and others from the abuse. Both the delay and the way in which she talks about the abuse indicate that it is a sensitive and difficult topic for the patient (Yu & Wu, 2015).

There is a delay before the doctor responds, and when he does it is a minimal "mmm." This leads to the patient responding with the addition of a quiet "so yeah" at line 31. This concluding phrase indicates she is finished and is not going to go into more detail. This is followed by a long silence, after which she speaks again, adding more to her answer, not talking about the abuse, but going back to how to how it's affecting her now (line 33), "I think it's sort of coming out no:w more than eve:r". Here, there is a combination of mitigation, "I think it's sort of" with an extreme case formulation: "more than ever". This treats this as delicate but also avoids talking about the abuse she experienced as a child by moving back to discussing the effects on her now (depression/counselling). Just before she takes this turn, she has touched her face, and as she speaks is looking at her hand. The companion is looking at her at this stage. The companion moves to place his hand on her leg around "coming out now more than ever" (Figure 6.3).

```
32                (3.6)(A)
33     Pat:       [I think it's sort  of
                  [(B)
34                com[ing out  no:w more than [ever
          [(c)                                [(D)
```

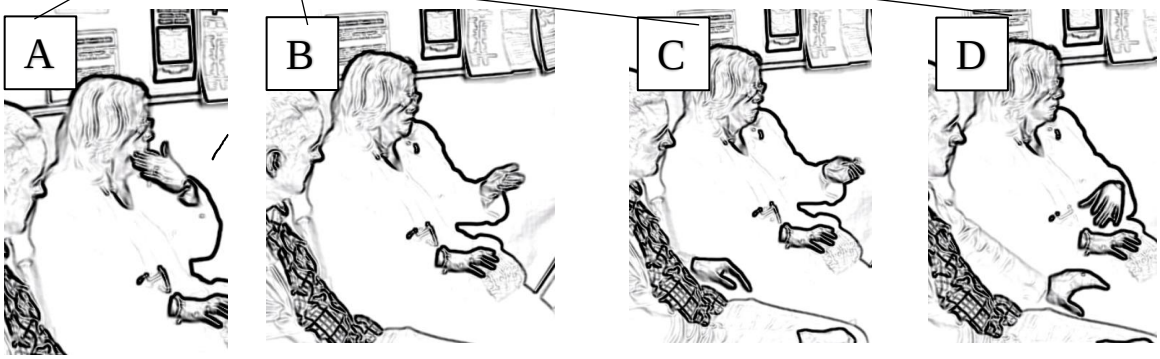

Figure 6.3 timing of the companion's hand movement with the patient's response .

The patient's embodied actions (the face touching) may also be another indication of the emotionally delicate nature of the subject they are discussing. The companion touching the patient's leg occurs close to the patient touching her face, whilst gazing down, looking at her hand rather than at the doctor. After this point, the companion does not try to talk; the companion's touch is not acknowledged visibly or verbally by the patient or doctor.

The next extract is on a similar topic, counselling and abuse. Both counselling and past abuse are subjects which can be emotionally loaded or difficult to discuss, and in this case there is a much more explicit explanation and display from the patient of how this topic distresses her. The touch, coming after a moment of distress when the subject has already been addressed calmly, is more visible in this extract.

Case 2 [170: Spouse: 15.22] (I don't like to talk about it)

```
01    Doc:     And what kind of treatment for these
02             blackouts?=
03    Pat:     =Nothing.
04             (2.8)
05    Doc:     No: tablets an n:o=no talking treatments
06             either=no counselling.
07             (0.8)
08    Pat:     tch I have cou:nselling but that was just
09             throu:gh but not for the
10             blackout[s  just  general]
11    Doc:             [So what was the ]counselling fo[r?]
12    Pat:                                             [.h]hh
13    Pat:     Hhhh Just relationship break-ups: and er (3.8)
14             sexual abuse basically.
15             (0.5)
16    Doc:     And wa- wa-  when did you have this
17             co[unselling?]
18    Pat:       [No, it  wa]sn't it wasn't >sexually< it was
19             e:r (1.8) I'd been with my partner for ten
20             yea:rs .hh and me daughter came to me when she
21             was f:ourteen and told me that (0.4) me
22             partner had bee:n (0.6) sexual abusing her.
23    Doc:     Mm.
34    Pat:     So: (0.4) that's why I got the counselling=
35             not fo:r (0.4) this.
36    Doc:     hmm,
37             (2.0)
38    Pat:     Bu:t it were:n't li:ke there were no proof >or
39             anything like that< so: (2.0) °that were l-
40             that were quite a long time [w e r e n 't   it?°]
41                                         [((turn gaze at pat))]
42             (0.2)
43    Doc:     Have you split up from this partner?
44    Pat:     Oh god yea:h. °haha°
45             (2.4)
46    Pat:     But >he said and she says it's he said< (0.2)
47             she didn't she said >he did but I me:an<  .hhh
48             (0.4) I dOn't tAlk about that really I just
49             keep t[hat] to the bottom=its something I=
```

```
50    Doc:           [Mm.]
51    Pat:     =don't talk °about°.
52    Doc:     So when did you have that counselling?
53             (1.6)
54    Pat:     E::h (0.2) after that [after-
55    Doc:                           [So how lo]ng ago was
56             that? ((Doctor looks at notes, touching page))
57             (1.4)
58   (Doc):    °mm:°, (( Doc moves page)) °mm:?°
59             (2.8)
60    Com:     About three years ago >weren't it?<
61    Pat:     Yeah (0.2) I've had it two or three times.
62             (0.4)
63    Doc:     Mm.
64             (0.4)
65    Pat:     E:r (wa) last one was three years ago.
66             (2.0)
67    Doc:     And wh-why did you have the counselling=what
68             kind of problems did you have=why did why did
69             you (0.2[) ask for it?]
70    Pat:             [I couldn't co]pe I couldn't cope with
71             the::
72             (1.0)
73    Com:     I think something were mentioned and it
74             brought it all back up [didn't it?]
76    Pat:                            [You see YE]:ah what it
77             is i- i-hh .hh  It got mentioned agai:n.
78             (0.2)
79    Pat:     A:nd it brought it all back up=so: i- i- .hh
80             IF I talk about it makes me feel ill. ((Fig. 6.5A))
81    Doc:     Mmm.
82             (2.6)
83    Pat:     ~But that's [not to do with~ tha:t
84    Com:                 [  ((looks   at    Pat))((Fig. 6.5B))
84             (0.6)
85    Pat:     That's not to do with me [°blackouts.°
86    Com:                              [(( unfolds arms))((Fig. 6.5C))
87    Com:     [((strokes Patient's hand))((Fig.5.7)
88    Doc:     [ Mm.
89             (0.6)
90    Pat:     Its something you don't [like to ~talk about.~
91    Com:                             [(( holds Pat's hand, Fig. 6.7))
92             (5.2)
93    Doc:     Other than that you mentioned your
94             gallbladde:r? Have you had any other health
95             problems in the pa:st?
```

After this extract, the companion continues to hold the patients hand for the next few minutes while the doctor continues with history taking questions.

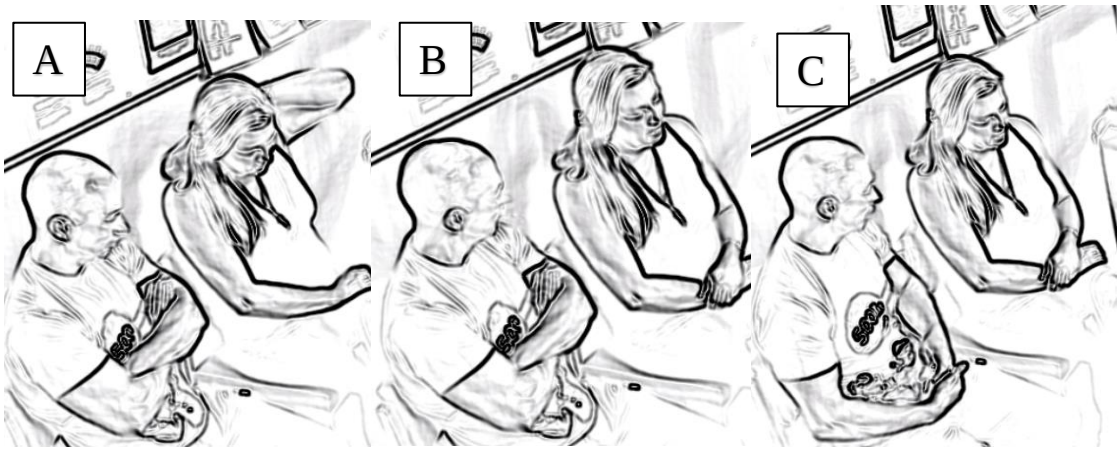

Figure 6.5. Companion unfolds his arms.

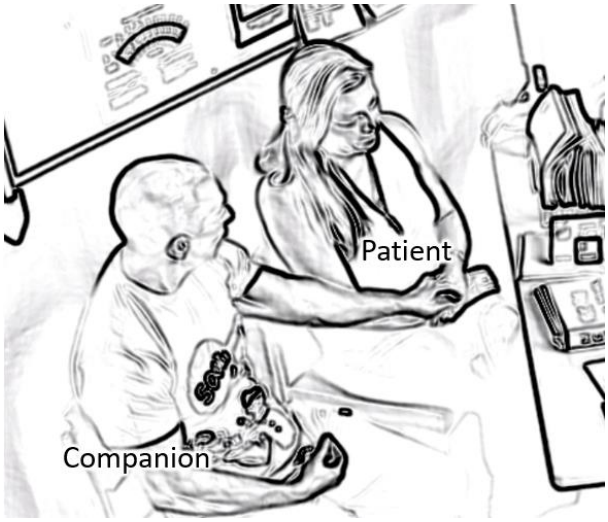

Figure 6.6 Companion strokes patient's hand (line 87)

Figure 6.7 Companion holds patient's hand (line 91)

In Case 2, the topic is also about counselling history and sexual abuse. Counselling history itself may be a topic that is treated as sensitive and with delicacy by the participants.

Counselling is introduced as a follow up enquiry about treatments for the patient's blackouts at line 02-03. The patient replies very quickly "nothing" (line 03). After a substantial silence (2.8 seconds) the doctor lists some possible treatments she could have had, " no pills, no talking treatments, no counselling". The turn is designed in response to her "nothing" answer, to check that the patient really didn't have any kind of treatment, and suggests his scepticism. The patient's response at lines 8-10 indicate the doctor was right to be sceptic; she now admits to having had treatment. Drew (2003) explored this pattern of repair-initiation/scepticism by doctors in response to what turn out to be exaggerated claims by patients, followed in response by partial retractions. However, two of the three treatments listed are psychotherapy/ counselling related (talking therapy). Another silence follows before the patient confirms that she has had counselling at line 08. While this response confirms having counselling, the patient discounts the relevance of the counselling therapy because she was not receiving counselling for the blackouts.. Both the doctor's delicacy in asking about the counselling and the patients resistance in talking about it, or its reliance are indications of how counselling is treated as sensitive topic to broach by the participants. As in Case 1, the patient, gives a minimal answer in the sense that she only confirms and does not give the reason for them, just that it was general, and it is the doctor who pursues a reason for the counselling.

```
11    Doc:             [So what was the ]counselling fo[r?]
12    Pat:                                              [.h]hh
13    Pat:     Hhhh Just relationship break-ups: and er (3.8)
14             sexual abuse basically.
```

The patient's answer is not very long; as in case 1, she gives a headline for her reason for counselling. There is no subject mentioned in it, for instance concerning who broke up with whom, or who was the victim or perpetrator of the sexual abuse, thereby distancing herself and others from these subjects. The "just" preface minimise it before relationship break-ups, and the mention of sexual abuse is delayed after an "er" and a long pause (3.8). The "basically" added on sums it up as a subject headline, much like "so yeah" in case 1, and does some work to down play it.

More silence follows before the doctor asks another follow up question, drawing out more information, bit by bit. This turn does not have a smooth start, with several cut offs, before he asks about when the patient had this counselling. In the patient/s answer at lines 18-22, her earlier avoidance of mentioning subjects of the sexual abuse (both the victim and perpetrator) causes trouble in this extract that she orientates to and tries to clarify.

```
18    Pat:       [No, it  wa]sn't it wasn't >sexually< it was
19             e:r (1.8) I'd been with my partner for ten
20             yea:rs .hh and me daughter came to me when she
21             was f:ourteen and told me that (0.4) me
22             partner had bee:n (0.6) sexual abusing her."
```

The construction of this talk also shows some of the delicacy about talking about the abuse - there are for instance multiple repairs and pauses. Mention of sexual abuse, is again left until the end of the utterance. It is similar to observations by Yu and Wu (2015) in how people treated subjects as delicate by delaying them until the end of the turn. The patient also constructs the clarification in a particular way; instead of saying "it wasn't me it was about my daughter" she first gives details about how long she had been with her partner and the age of her daughter. The way she formulates talking about the incident is marked. She not only reports it not as something that happened to her daughter, but something her daughter reported happened, indicating her own epistemic distance. But she formulates the action as her daughter "came to me (when she was fourteen) and told me that (0.4) me partner has been (0.6) sexual abusing her". This puts the action of her daughter coming to her and telling her in prime position of the narrative, as well as highlighting her daughter's age. There is a pause both before mentioning her partner "(0.4) me partner" and the abuse "(0.6) sexual abusing her".

The turn delicately handles the explanation for her counselling, and the emotional relevance to her - it was her partner of 10 years, and her fourteen-year-old daughter came to her about the sexual abuse - but it also constructs the story in a way that sets out first the normality, before revealing the distressing aspect. By referring with a hendyadic construction to her daughter having come to her saying she had been sexually abused, the patient leaves some room for doubt in what happened. It is something her daughter said happened rather than something that happened. It puts emphasis on the accusation rather than the abuse, but also mitigates her epistemic claim to knowing what actually happened. This is later emphasised when she explicitly talks about how it was difficult for her to know whom to believe.

```
38    Pat:     Bu:t it were:n't li:ke there were no proof >or
39             anything like that< so: (2.0) °that were l-
40             that were quite a long time [w e r e n 't   it?°]
41    Com:                                 [((turn gaze at pat))]
42             (0.2)
43    Doc:     Have you split up from this partner?
44    Pat:     Oh god yea:h. °haha°
45             (2.4)
```

```
46    Pat:     But >he said and she says it's he said< (0.2)
47             she didn't she said >he did but I me:an<  .hhh
48             (0.4) I dOn't tAlk about that really I just
49             keep t[hat] to the bottom=its something I=
50    Doc:           [Mm.]
51    Pat:     =don't talk °about°.
```

This (whom to believe) is itself treated as delicate matter to talk about, and she builds a case for having being torn between conflicting stories. Not only is this an emotional issue, but it is one where there is a lot at stake, including how she is perceived as a mother and a partner. At line 40 she ends with a tag question that seeks confirmation of her account from her companion. This is followed by silence, and then a follow up question at line 43. This question, if she is still with the partner, is treated as laughable by the patient. But when it is not followed by another one, she orientates to it needing more explanation about how it was hard for her do know what happened (line 46), she uses the idiomatic expression "he said she says" and expands it to describe how difficult it was to tell what was true given that she had only their versions. There is another pause, which is followed by a marked elevation in the volume of her voice, as she explicitly says she doesn't talk about it. She repeats that does not talk about it multiple times in her talk. "I dOn't tAlk about that really I just keep t[hat] to the bottom=its something I=don't talk °about°".,She does not say it once, but repeats it by saying it slightly differently "I just keep that to the bottom", alluding to suppressing it. This is followed by repeating "It's something I don't talk about". This is repeated later lines 79-80: "A:nd it brought it all back up=so: i- i- .hh IF I talk about it makes me feel ill." This gives an account of why she does not talk about it. She again repeats that that she doesn't talk about the topic at like 90, this time replacing "I" pronoun with "you", constructing it as a generalizable thing that people wouldn't talk about. "Its something you don't [like to ~talk about.~ "

The subject unfolds step-by-step; the doctor asks questions, and the patient answers with only that information; these answers, combined with the self-repairs, silences, mitigation and delays are ways in which the delicacy of the topic environment is displayed in the talk. Her repeated accounts for not saying more are self-reported evidence that this is not an easy topic for her to discuss.

Her difficulty with talking about the subject is also indicated by the emotional quality of her voice. Her voice begins showing signs of upset (most notably with voice starting to waiver at line 83: "~But that's [not to do with~ tha:t" (as shown in the transcript "~ "signifies wobbly voice (Hepburn & Potter, 2007) At this point (line 84, Figure 6.5B) the companion's gaze turns to the patient. As she continues to talk her voice is soft and slightly strained which

leads to the companion to shift his gaze towards her. At line 86 the companion unfolds his arms (Figure 6.5C) to stroke her hand with his fingers at line 87 (Figure 6.6). Her voice noticeably wavers again at line 90 “Its something you don’t [like to ~talk about. ~” which is the point where the companion stops stroking her had and holds it (line 91, Figure 6.7).

Case 3 occurs when a different subject is being discussed. The patient is describing his seizure. This case shows that this kind of touch can occur in places where the emotionality of the talk is more ambiguous. There is no outward display of emotional distress, as seen in Case 2, and Case 4, or explicit reference to negative emotion as shown in case 1 (depression). However, there is evidence that the patient is treating the subject as delicate, and the manner in which he constructs his description of the attack suggests it was negative experience for him.

Case 3 [169: Spouse: 0.32] (Funny Feeling)

This extract takes place at the beginning of the interaction. The doctor asks an opening question and the touch occurs during the patient’s problem presentation.

```
01    Doc:    What can I do for you:?
02    Pat:    U:m (0.6) <she weren’t sure it’s u:m>
03            .hhh °i’m trying to° I get a funny
04            [feeling in the back of my neck like a pressure feeling.]
05    Pat:    [((touches back of neck)  (Figure 6.15A))                ]
06    Doc:    Mm hmm,
07    Pat:    And I feel right heavy headed (0.6) and I just lose a:ll
08            (0.5) not so not so much feeling but (0.6) all
09            the strength sucked out
10            [of me and I just drop where I’m standing.
11    Com:    [((lifts arm up to adjusts bra (Figure 6.15B)))
12            (1.4)
13    Com:    [((Com holds Pats hand ))] ((Figure 6.10C))
14.           [         (2.0)          ]
15    Pat:    It started Christmas Da:y.
16            (3.8)
17    Doc:    Christmas Day you were last here?
18    Pat:    Yeah.
19            (1.8)
20    Doc:    So what can you tell me about the fi:rst attack?
21            (0.9)
22    Pat:    A::h we got up (0.2) kids opened all their presents.
23.           (1.5)
24            And ah we had breakfast=I washed the pots.
25    Doc:    Mm hmm.
26    Pat:    A:nd I just went in the roo:m and I felt (0.4) just had
27            this feeling and I just dropped on the sofa.
```

In Case 3, the patient is describing his first attack, where he lost consciousness suddenly on Christmas day. The talk preceding the touch it is not neutral. The account of the attack is produced delicately. He restarts his account multiple times: “U:m (0.6) <she weren’t sure it’s

u:m>” is not completed, instead there is an in breath followed by “°i’m trying to°” this is also dropped and he restarts with “I get a funny feeling in the back of my neck”. The patient displays, with the vague description and the multiple restarts, difficulty in formulating a description of his experience. This sense of difficulty in describing how it felt continues as he gives his account. In his turn for lines 08-10, he goes into more detail about what happens, using a narrative; “not so much feeling but (0.6) all the strength sucked out” which indicates more of this awkwardness about communicating the sensation. “not so much feeling” describes it as *like* feeling but not sufficiently like it, and more like strength. By formulating it this way it gives the sense that neither the words “feeling” or “strength” are sufficient in describing his experience, but strength is more so.

While the patient is displaying delicacy in the sense of trying to describe something not easily described, he is also indicating the emotional impact of the experience in the way he formulates the account. For example the added “right” in “I feel right heavy headed”, and “just” and “all” in “I just lose all..” emphasise the description as something extreme. The way he describes the feeling of strength leaving him is also violent, and something that is done to him, “sucked out of him”. This continues with he “just drops where he is standing”. The use of “just” and “where I am standing” indicates some of the suddenness. It also alludes to a more dramatic fall, from standing. In doing this he is describing it in a way that portrays him as vulnerable. As in case 2, the narrative of his experience covers increasingly serious details, ending with him ‘dropping where he is standing.’

As he says that the strength was sucked out of him, the companion unfolds her arm and seemingly adjusts her bra strap. This has the added effect of making it easier for her to segue into reaching over to hold his hand (Figure 6.15).

Figure 6.15 Companion unfolds her arms, and adjusts her bra strap before reaching to hold the patient’s hand. (lines 05, 11, and 13)

As in previous examples the touch is preceded by a silence, where the doctor had an opportunity to speak. In this case there is a 1.4 second silence before the companion reaches over to hold the patient's hand. After another (2.0) pause, where the doctor still has not spoken, the patient begins to tell in more detail about the first incident. "It started Christmas Day."

The patient does not say anything else and there is another longer silence, 3.8 seconds, before the doctor asks a follow up question about Christmas Day. As in case 1, the patient answers minimally until the doctor askes another question to get the patient to expand.

While the patient is revealing something different in this case it is still a revelation about something he is portraying as distressing. It is also something he displays difficulty talking about, though in this case some of that difficulty seems to be associated with a sensation that is hard to put into words. The talk around it is formulated delicately, with silences, and self-repair. He does not immediately say that he lost consciousness, but instead builds up to it until it is revealed at the end of his turn.

While there is no touch in case 4, there is some evidence that the doctor and patient orient to the topic as a sensitive one. As in previous cases this is a delicate sequential environment. This is both observed in how the doctor discusses her diagnosis, and in the patient's emotional reaction.

Case 4 [186: Parent: 09.01] (I'm Fine)

```
01    Doc:     I think that (0.8) does push me towards
02             thinking: (.) these are epileptic attacks,
03             (0.4) >Epileptic attacks< tend to be <very>
04             >stereotyped<.= (They're) the same each
05             ti:me. .hh whereas emotional type attacks
06             tend to gradually change over the yea:rs.
07             (0.2)
08    Doc:     And yours have never changed.
10    Pat:     ((Pat shakes head))
11    Doc:     .hh The other- The other thing which is some
12             evidence, that they're epileptic, is that they
13             do seem to have impro:ved- (0.2) a little bit,
14             (.) at least. with the tegreto:l, >which is<
15             what you'd expect.
16             (0.4)
17    Doc:     .hh Emotional attacks: (0.4) #e::h# there's
18             not usually any (0.4) consistent
19             improvement °with the Tegretol°. ((Figure 6.16))
20             (0.6)
21    Doc:     .hh Now th[e obvious approach] (0.4) if you're
22    Pat:               [((looks  to  Com))] ((Figure 6.17))
23    Doc:     getting some response >to the Tegretol< is
24             simply to increase the
25    Doc:     Tegre[tol:, and see if you ]get a better=
```

```
26    Com:          [((sits up straight)) ] ((Figure 6.18))
27    Doc:     =response.
28             (0.2)
39    Pat:     °>yeah<°
30             (0.4)
31    Doc:     .hh Tegretol is a very s:afe (0.6) drug.
32             (0.2)
33    Pat:     Yea[h, I've be]en on them °be°fore?
34    Doc:        [You  don't]
35    Doc:     You ca:n't injure yourself >with
36    Doc:     [Tegretol<.= e]ven if you take-
37    Com:     [You alright?]
38             (0.2) ((Fig.18))
39    Pat:     yeah?
40             (0.2)
41    Doc:     °you okay?°
42             (0.2)
43    Pat:     °M: hm?°
44             (1.2)
45    Doc:     ((gives Pat tissues, Fig. 19))
46    Pat:     No, it's ~fine?~
47    Pat:     ((Pat takes a tissue))
48    Doc:     tk! E- E- Even if you take (you) a- a big uh-
49             uh >overdose of Tegretol<.= It doesn't make
50             any: (0.4) u- uh it doesn't do you any harm.=
51             You've just to wait for it to wear off.
52             (0.4)
53    Pat:     (                  ).
54    Com:     hh hi ha °ha ha°
55    Doc:     A- are there- #a-# are <th[e:re]> (0.8) other
56    Com:                              [hmh!]
57    Doc:     issues that- that- y- I mean you're obviously
58             upset.
59             (0.2)
60    Pat:     (Woh- I- I'm just-) well you're saying t#hat#
61             (.) you think they're epileptic, I've just
62             always #want#ed to 'ear, .hh #wha#t they could
63             be?
64    Doc:     M:.
65             (1.4)
66    Pat:     So:.(0.4).hh >I just< wanted to have a ~na:me
67             for it?
68             (0.4)
69    Doc:     Yeah.
70             (0.2)
71    Doc:     I think it's important?
72    Doc:     °ye:s.°
73    Pat:     (ye ).
74              [(1.0)
75    Pat:      [(( puts[ hand on face))
76    Com:              [ lifts arms and starts to move]
77    Pat:     I'm [f[in-   [I']m    fi:ne.   ]
78    Pat:         [(( Looks at com and leans back away from com
79    Com:           [huhuhu   ]
80    Com:           [((Com stands up))]
81             [((Com sits back down))]
82    Com:     [Y[ou're]      £fine   ]
83    Pat:       [I:'m-]
84             (6.0)
85    Doc:     So the approach we would no:rmally adopt i::s:
86             (0.2) u::m
```

Figure 6.16 Doctor explains diagnosis (lines 01-20).

The doctor gives the diagnosis over an extended stretch of talk. He introduces the diagnosis in relation to the evidence for it. “I think that (0.8) does push me towards thinking: (.) these are epileptic attacks,” He does not say directly what he thinks they are, but rather phrases the turn that the evidence is “pushing” him towards that conclusion. He then builds more of a case of evidence for it, describing how epileptic attacks are different from emotional ones. This formulation treats the delivery of a diagnosis as a delicate action. The doctor takes time to explain the reasoning for the diagnosis, and what it means for treatment. It is during this explanation of the diagnostic evidence that the patient glances at her mother (who is mostly off camera at this point), with an upset expression (lines 22 -24.)

```
21    Doc:     .hh Now th[e obvious approach] (0.4) if you're
22    Pat:               [((looks  to  Com))] ((Figure 6.17))
23    Doc:     getting some response >to the Tegretol< is
24             simply to increase the
25    Doc:     Tegre[tol:, and see if you ]get a better=
26    Com:          [((sits up straight)) ] ((Figure 6.18))
```

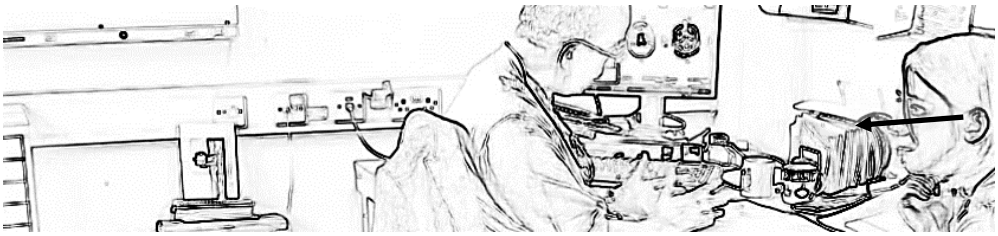

Figure 6.17 Patient’s gaze shifts to companion (Line 22)

Figure 6.18 Companion sit's up straight, attention on patient (line 26)

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Following the patient's glance at the companion with an upset expression (line 22), the companion changes her posture, sitting up straight and looking at the patient. This brings her into the camera frame. Her gaze does not leave her daughter's face, even though her daughter has turned back to the doctor, evidence that her attention is focused on the patient, possibly monitoring her for more signs of upset. The doctor has not reacted to her display of emotion at this point. From lines 27-36 the doctor and patient continue to discuss Tegretol (an anti-epileptic drug). In this exchange it is mostly the doctor talking; the patient answers only minimally, often after a silence.

The companion begins speaking in overlap with the doctor at line 35, interrupting the talk about Tegretol and causing the daughter's gaze to shift to her.

```
35    Doc:     You ca:n't injure yourself >with
36    Doc:     [Tegretol<.= e]ven if you take-
37    Com:     [You alright?]
38             (0.2) ((Figure 6.19))
39    Pat:     yeah?
40             (0.2)
41    Doc:     °you okay?°
42             (0.2)
43    Pat:     °M: hm?°
44             (1.2)
45    Doc:     ((gives Pat tissues, Figure 6.20))
46    Pat:     No, it's ~fine?~
47    Pat:     ((Pat takes a tissue))
48    Doc:     tk! E- E- Even if you take (you) a- a big uh-
```

Figure 6.19 Patient looks at companion as companion says, "are you alright" (line 38)

Figure 6.20 Doctor reaches for tissues.

The turn (line 37) is an emotion check, displaying an orientation to her daughter's visible upset. This shifts the talk away from Tegretol and onto the patient's emotional state. The daughter gives a delayed response that she is fine, but the delay and her facial expression do not quite indicate that she is alright. This may be why the doctor also checks that she is okay at line 43: "you okay?" The patient's "mhmm" at line 45 sounds affirmative rather than negative, but like her previous answer to the companion may be indicating otherwise, especially visibly as her hand is covering her mouth. The doctor orients to her displaying some upset and reaches for the tissues on his desk to pass to her. While she verbally rejects the non-verbal offer (of tissues) 48, she does take a tissue on line 49 and uses it to wipe her face.

The doctor then returns to discussing Tegretol on line 50, initially with some difficulty (cut off "E- E-"), by repeating line 38, " even if you take" to finish off what he was saying about the benefits of Tegretol. The patient responds, though it is hard to hear exactly what she says, but the companion laughs in response.

At line 57 the doctor asks, with some difficulty, whether there are any other issues, signalling a switch to a different topic. Half way through the topic, he mentions once again how upset she seemed.

```
55    Doc:     A- are there- #a-# are <th[e:re]> (0.8) other
56    Com:                              [hmh!]
57    Doc:     issues that- that- y- I mean you're obviously
58             upset.
59             (0.2)
60    Pat:     (Woh- I- I'm just-) well you're saying t#hat#
61             (.) you think they're epileptic, I've just
62             always #want#ed to 'ear, .hh #wha#t they could
63             be?
64    Doc:     M:.
65             (1.4)
66    Pat:     So:.(0.4).hh >I just< wanted to have a ~na:me
67             for it?
68             (0.4)
69    Doc:     Yeah.
```

```
70                (0.2)
71      Doc:      I think it's important?
72      Doc:      °ye:s.°
73      Pat:      (ye ).
74                 [(1.0)
75      Pat:       [(( puts[ hand on face))
76      Com:               [ lifts arms and starts to move]
77      Pat:      I'm [f[in [I']m    fi:ne.   ]
78      Pat:          [(( Looks at com and leans back away from com
79      Com:            [huhuhu]
80      Com:               [((Com stands up)) ] (( Figure 6.21 ))
81                [((Com sits back down)) ] ((Figure 6.22))
82      Com:      [Y[ou're]      £fine    ]
83      Pat:        [I:'m-]
84                (6.0)
85      Doc:      So the approach we would no:rmally adopt i::s:
86                (0.2) u::m
```

Figure 6.21: Companion stands up (line 80)

Figure 6.22 Companion sits back down. (lines 81-82)

In response to the doctor mentioning her upset, the patient gives an account for her display of emotion from lines 62-70. The emotion in her voice is hearable with croaks and wobbles throughout her account. The account downplays the upset, "I'm just" etc. constructing it is as

she is just a bit emotional finally having a name for the attacks, and her upset does not need to be addressed. These are shown in the transcript with the # for croaking, and ~ for wobbly voice. This is similar to the previous case in that the patient is revealing something personal in giving this account. Eg. Her relief of having a diagnosis and what it means to her.

As in previous extracts, the doctor responds minimally, after a silence. There is an orientation to the delicacy of responding to these kind of self-revelations. There are multiple silences following the account (lines 65, 68, 70 and 74). The doctor's answers are minimal, e.g. "mm" and "yeah." After the 0.2 silence at line 70, following his own "yeah" where no one has come in, the doctor expands, "I think that is important" as a means to align with the patient's account.

At line 77 she responds softly with what sounds like an affirming noise, but it is unclear, and puts her hand to her face. This kind of self-touching, as in case 1, is also a feature that indicates something self-conscious or awkward about the topic environment for the patient.

The companion, who has been monitoring her throughout her account and this exchange, begins to move and raise her arms. The patient reacts to this by reassuring her that she is fine, (line 81) and turning her gaze to her companion. This reassurance shows that the patient orients to the companion's movement as reactive to her emotive display. In response to the "I'm fine" the companion does a soft chuckle and continues to move standing up from her seat. The patient orients to this as conveying the intention to get closer to her, and refuses both by leaning back (out of frame) and repeating "I'm fine" (Fig. 20). The companion accepts this rejection by sitting back down, and repeating (with changed pronouns) "your fine," with a smiley/soothing tone (indicated by the £ symbol in Fig. 21, Lines 81-82). After this the interaction goes back to a clinical topic, with the doctor steering it back to talking about treatment at line 86.

The attentiveness of the mother, in monitoring her daughter in extract 4 (with her gaze and posture) is similar to how the companions in extracts 1 and 2 shift their gaze and change their posture to their patient before holding their hand/ placing a hand on their knee. The companion can be seen to be monitoring the patient's emotional state, but in this case the companion verbally checks the patient's wellbeing. The consequences of this disruption to the sequence about diagnosis and treatment is that a tension emerges between the topic of the patient's reaction to the news and the news itself. In comparison to previous cases, in which the companion's touch is not remarked upon, one of the reasons for the touch could be to acknowledge a matter that is not really or officially part of the topic they are discussing. It

does not disrupt the talk but allows the companion to convey her acknowledgement and support.

The emotion itself becomes the delicate topic of discussion as the patient consistently pushes back at talking about it, until the moment she gives an account for her upset. This account is similar to cases 1-3 in she is revealing something delicate and personal about her experience, and that a response from the doctor is delayed and minimal. It is after this that the companion attempts to get closer to her, and her attempt is refused.

As in cases 1-3 the companion moves so as to be physically closer to the patient during this part of the interaction. However due to the distance between them this is not as easy as reaching and placing a hand on the patient, and she has to stand up. This also causes disruption and the patient rejects her movement to be closer both verbally and physically (by leaning back). In this case, the fact that the emotion becomes an "online" topic reveals a tension between the business of dealing with the emotional issue and continuing the business of the talk.

4 Discussion

This chapter has focused on companions touching patients at moments of particular interactional delicacy. It marks the final step towards the aim this thesis (to examine the companion's role in the seizure clinic) by showing how companions provide not only informational support (as was highlighted in the previous two chapters) but also emotional support.

The chapter has shown how companions touch patients at moments when the topic under discussion is something that is sensitive or difficult for them. The emotional features of the patient's talk and the way the delicacy of the talk is handled both by the patient and the doctor are linked. In all of the cases featured in this chapter, the sequential environment is not emotionally neutral, and some of the delicacy is managing that. There is a point in each of them where the patient answers in a way that reveals something personal about their experience that they display resistance to or difficulty in expressing. The way they formulate this is managed carefully, dealing with the delicacy of explaining an indescribable experience, distancing themselves from it, or managing things that might be at stake in revealing that account.

Leading up to these accounts, the doctor is displaying an orientation to that same delicacy in how he phrases matters, introduces the topic, and offers a minimal and delayed response following the personal reveal. The way in which the patient manages the delicacy of

these topics (especially in case 1 and 2 where the patient is talking about sexual abuse) is similar to how participants in Yu and Wu's (2015) study talked about sexual topics, even though both the contexts (their data was from a medical radio show) and language (Chinese) were different. A particularly clear similarity was in how both the patients in this chapter and the partcipants in Yu and Wu's (2015) held off mentioning the most delicate part of their talk until the end.

Case 3 was different from the other cases as there was not the same obvious emotionality. In this way it is an outlier, although it also shows that these kinds of touches can occur even when emotion is interactionally ambiguous. However, there is an element about this interaction that makes it look similar to the other two cases sequentially, including evidence in the way the patient describes his attack, in which he treats this subject as having a negative emotional valence. It is also possible that, due to the companion's relationship with the patient, she has access to the added context we are not privy to as observers. This is part of why this interactional sequence leads to her holding her spouse's hand.

The unobtrusive nature of these touches (in cases 1-3) may be part of their function in these sequences, as they can offer support or react to what the patient is revealing without further topicalising the sensitive nature of the environment. In case 4, the introduction of talk about the patient's current emotional state interrupts the interaction, and there is a tension between dealing with the emotion and continuing with the clinical business of the visit. Alongside all of this, the patient resists the topicalization of her distress (e.g. her repeatedly saying "I'm fine").

The proximity of the patient to the companion may be another part of the environment required for the touch to occur. In Case 4, movement to the patient was "bigger" and more noticeable because the companion got out of her chair to get closer. If one of the features of these touches is to offer non-disruptive support, their effectiveness in doing so is lessened by sitting further away.

This is a rare phenomenon, with only a few examples in my data set. However, this kind of touch may appear in other social settings and other medical settings, and another study looking at it with a wider range of data might reveal more. This chapter and analysis should therefore be seen as preliminary, highlighting that there appears to be something sequential happening in these touches that would benefit from further study looking at a larger collection of cases.

This analysis started with an overview of companion participation in the data. It then explored two specific aspects of this participation, focusing on how companions can provide

informational support by correcting patients' accounts and by acting as an informational resource when it comes to patients' medication. This final analytic chapter then looked at companions providing patients with emotional support by touching them at delicate interactional moments. Across all of these analytic chapters there have been some broad recurring themes and ideas. The discussion will now recap and bring these together.

CHAPTER 7 DISCUSSION

The aim of this thesis was to use CA to examine the role of the companion in seizure clinic interactions by analysing the position, nature, and consequences of their contributions. This served as the research direction for the thesis, which, due to the nature of CA, took an inductive approach, building findings from the data rather than answering specific research questions. This direction was informed by a general concern (expressed by clinicians and implicit in the literature) about the impact of companions on issues like patient-centeredness.

It was established at the outset that, while patients are asked to bring a companion along to their initial consultation as a possible eye-witness, the helpfulness of companions in this environment has been controversial. Some have noted their disruptive potential to patient participation (M. L. Clayman et al., 2005; Ishikawa, Roter, Yamazaki, & Takayama, 2005; Laidsaar-Powell et al., 2013; Robson et al., 2013), whilst others highlight the positive contributions that they can make (Clayman, Roter, et al., 2005; Ellingson, 2002; Laidsaar-Powell et al., 2013; Robson, Drew, & Reuber, 2016). Taking this debate as its jumping-off point (though with the ultimate goal of transcending it), my study looked at various aspects of the topic, ranging from the fundamental question of how it is that companions come to contribute in seizure clinic interactions to begin with, to more specific forms of companion participation at particular points within these interactions.

This chapter is divided into four sections. The first, “Summary of analysis”, summarises the analytic chapters of the thesis, reiterating the focus and findings of each one. The second section, “Contributions to triadic medical interaction literature”, highlights how this thesis fits in with existing work on the topics that this thesis has covered. The third section, “Limitations and directions for future research”, considers some of the limitations of this thesis and some of the under- and unexplored avenues that future research could pursue. The fourth and final section, “Conclusion”, provides a succinct summation of the upshot of this research.

1 Summary of analytic chapters

1.1 Chapter three: Companion participation

Chapter three was an overview of how the companion came to contribute across all 30 consultations. It first used coding to count the number of contributions from the companion, either invited by the doctor or the patient (explicitly (20%=405) or implicitly (27.6% n=553))

or volunteered by the companion themselves (42.6% n=854). This showed that companions were slightly more likely to be invited to talk either explicitly or implictly (47.7% of cases overall) than they were to volunteer (42.6% of cases overall).

With this descriptive statistical overview established, the chapter then proceeded to use CA to look in greater detail at the sequential contexts in which companions contributed. It was shown that, when companions were invited explicitly to contribute, this provided an informational resource for either the patient or the doctor. The doctor usually invited companions to provide their version of the patient's attack, while the patient sought either help providing or confirmation of their own answer to the doctor's questions. Doctors rarely used implicit invitations, while patients used both explicit and implicit invitations in roughly the same sequential context (when they were displaying difficulty in answering). Companions self-selected to contribute at three recurring sequential positions - just after the patient had answered (in response to the patient's answer), instead of the patient (in response to the doctor's question), and after a sequence or topic had ended (where they initiated new topics/asked questions). Patients frequently took ownership of companion's contributions by repeating them when the companion answered after them or instead of them.

This chapter also highlighted that companions, even when they self-selected to speak, oriented to the patient's rights as primary respondent. It was also shown that the level of the companion's participation was co-constructed by all participants, with doctors either taking up the companion's contributions or redirecting talk back to the patient.

1.2 Chapter four: Upgrading corrections

Chapter four focused on instances where companions correct patients in a way that upgraded the severity of their account of their symptoms. It was shown how these corrections occurred in a 3-stage sequence:

Stage 1: The doctor asks a diagnostic question

Stage 2: The patient answers with a 'no symptom' report' or downplaying symptomatic severity

Stage 3: The companion corrects the patient's answer, upgrading the symptomatic severity

By making such corrections, companions provided an alternative version to that in the patient's answer, an alternative to which the neurologist would not have had access had the companion not been present. This chapter thus showed the companion's importance to the information-sharing aspect of the consultation.

1.3 Chapter five: Companion contributions to discussions about medication

Chapter five opened with the observation that companions were frequently involved in discussions about medication. It was found that, in about two-thirds of the recordings (n=20), the companion contributed at least once to a discussion about medication.

These contributions typically occurred in either the history-taking phase or the treatment recommendation phase of the consultation. In-depth analysis revealed how, in the history-taking phase, companions acted as an information resource to be drawn upon by either the patient or the doctor. Sometimes they were recruited to contribute information about medication because the patient either struggled to answer or provided an answer that was insufficient. On other occasions, companions mentioned medication while in the process of answering another question. In these cases, the companion used the topic of medication to propose a diagnostic theory of their own, creating common-sense inferences of causation that the doctor could pursue. In the treatment recommendation phase, meanwhile, they adopted a more proactive role, prompting the patient to ask questions, or taking the initiative and making suggestions, or posing questions, of their own.

The companion's role in discussion about medication differed therefore between the history-taking phase and the treatment recommendation phase. In the history-taking phase, companions acted largely as a passive informational resource. In the treatment discussion phase, on the other hand, they acted as surrogates, initiating topics when the patient themselves was unable or unwilling to do so (though while still maintaining their orientation to the patient's rights as principal respondent) as well as displaying their own stake in the treatment decision.

1.4 Chapter six: Companions' supportive touching in delicate sequences

This chapter focused on instances of companions touching patients as a form of emotional support. It discussed, first of all, how companion-patient touching was relatively rare in the data, occurring in only five cases out of 26.

The chapter went on to focus on three of these cases and one failed touch. These cases stood out because they occurred when the patient was revealing something vulnerable, or the topic being discussed was awkward, sensitive, or emotionally distressing. In two of the examples, furthermore, the touching occurred alongside an emotional display (e.g. crying, wavering voice, or an emotional lexical choice).

Given this recurring sequential position, it was shown how touching served an important emotionally-supportive function. Crucially, in the cases where the touches came off successfully, they served this function without disrupting the institutional business of the interaction. In the case where the touch failed to be completed, however, and the companion verbally checked her patient's wellbeing, the institutional business was indeed disrupted.

2 Contributions to triadic medical interaction literature

Chapter two (the literature review) of this thesis highlighted several recurring themes in the existing literature (both CA and non-CA) on triadic medical interaction. The themes that relate most to this thesis were: how the companion was selected (or self-selected) to speak via turn-taking; the diagnostic relevance of the companion's interaction with the patient; companions as providers of informational and emotional support; and the implications of companions for patient-centeredness and autonomy. This section will highlight how this thesis has contributed to each of these themes.

2.1 Turn-taking and participation

In chapter 3 I showed the various ways in which companions could be brought into the interaction – by being invited verbally and non-verbally (via gaze) to participate in consultations, and by volunteering to speak when the sequential context called for it. These findings both support and extend existing research on companion participation (Fukui et al., 2011; Meeuwesen & Kaptein, 1996; Stivers, 2001; Stivers & Rossano, 2010; Tates & Meeuwesen, 2001; Tiitinen & Ruusuvuori, 2012),that describe how participation in triadic medical encounters is negotiated by all parties through turn-taking practices such as the use of gaze, head-turning and question design.

These findings also allow for greater insight into, and recontextualisation of, existing research. Robson et al. (2013), for example, showed that patients tended to participate less in the interaction (as measured by the amount of words spoken) when they were accompanied by a companion. While the present research does not contradict this finding, it does suggest that the companion's impact on the interaction (negative or positive) cannot be measured solely by the amount of words spoken by the patient. After all, as we have seen, even when the companion was speaking instead of the patient, they still oriented to them as primary respondent and gave them the chance to talk. This suggests a more nuanced and complicated picture than the traditional view of the companion simply eating into the patient's time.

As mentioned previously, companion participation in the data used for this thesis had previously been analysed in Robson (2013) and Robson et al. (2013, 2016). This meant that that there was, to some extent, overlap between their research and chapter 3 of my analysis. However, because Robson et al.'s (2016) interest was in diagnosis, and because she restricted her focus to the history-taking phase, her interpretation of the sequences was slightly different. She found that companions responded to patients "resistance answering questions", which aligned with NES patient communication profiles. I, on the other hand, interpreted the companion in such sequences as responding more broadly to "difficulty".

This does not mean that Robson's findings and mine in chapter 3 are incompatible. Rather, the two analyses complement each other, with hers looking at companion participation from a specifically diagnostic perspective, and mine looking at it from a broader turn-taking perspective.

2.2 Informational support

Informational support and the facilitation of understanding are two of the roles that companions have in consultations (Cordella, 2011; Ellingson, 2002; Laidsaar-Powell et al., 2013; Street & Gordon, 2008). An effective informational exchange is often seen as the desired outcome of a medical encounter, meaning that the focus is often on factors that facilitate information exchange (Wassmer et al., 2007). How much information is shared is also often used as a measure or indication of how useful or disruptive the presence of a companion is (Wolff & Roter, 2008).

This study showed companions providing informational support in several ways. The most obvious was in their capacity as an informational resource, offering eyewitness accounts of patients' seizures, along with other information about their lives and medication, that could be drawn upon by both the doctor and the patient (chapters 3 and 5). The companions in this

thesis also provided informational support by adding additional information (Chapter 3), correcting the patient's answers, and providing an alternative accounts, (chapters 3 and 4), orienting to the patient's difficulty in answering (and, sometimes, answering for them) (Chapters 3 and 5), and bringing in new information that they oriented to as important (chapter 5). Given that companions often did all of this in the face of patients' inability or reluctance, their presence meant that doctors had access to valuable information that they might not otherwise have had. This is particularly true for the findings in chapter 4, which focused on a particular sequence where companions corrected patients by upgrading the severity of the description of their symptoms, in response to patient's downplaying the severity.

Companions acted in a facilitative capacity, meanwhile, by initiating question-and-answer sequences at the end of the consultation (chapters 3 and 5). These questions might not have been asked had the companion not been present, which may explain why other studies have found that physicians give more information when a companions is present (Del Piccolo et al., 2014; Eggly et al., 2006; Labrecque et al., 1991; Laidsaar-Powell et al., 2013; Wolff et al., 2011). While there is no way of making this claim definitively based on this thesis alone, given that it is not comparative, supporting evidence can be seen in a study on breast cancer consultations showing that the presence of a companion increased the number of questions asked in consultations without suppressing the number of questions asked by patients (Del Piccolo et al., 2014).

2.3 Emotional support

While much of the existing research has focused on companions' informational support, comparatively little has focused on their emotional support. This can be explained by emotional support being harder to measure interactionally, as well as the fact that emotional support occurs between the companion and the patient without necessarily contributing to the 'official' outcomes of the consultation. Still, despite this lack of research focus, the importance of emotional support to the companion role has nonetheless been emphasised (especially in contexts where the patient has a chronic illness) (Ellingson, 2002; Kausar et al., 2013; Laidsaar-Powell et al., 2013; Street & Gordon, 2008).

Chapter 6 demonstrated that companions touched patients as a form of emotional support. This was based on the timing of these touches, which coincided with emotional displays (crying, voice breaking etc.) on the part of the patient. This argument is also supported by earlier research recognising touching as emotionally supportive (Ellingson,

2002). While the small number of cases makes it difficult to make a definitive case about the function of these touches (their coinciding with emotional displays might, after all, be a coincidence), this finding nonetheless marks a significant contribution to the (so far paltry) research on the companion's emotionally supportive role. This is especially true given that, again, earlier research has struggled to measure emotional support to the same extent as informational support.

2.4 Autonomy and patient centeredness

This thesis ties in with research on patient-centeredness and autonomy. Companions bring to the consultation another voice and agenda, leaving open the possibility that their presence could shift the focus away from the patient. This is also tied in with questions of relative levels of patient and companion participation, given that patient-centeredness is often measured by how much patients participate in the consultation (Ishikawa, Roter, Yamazaki, Takayama, et al., 2005; Laidsaar-Powell et al., 2013; Ruusuvuori, 2001).

This thesis contributes to this discussion because it shows that, when companions speak in consultations, they do not do so unilaterally in a way that impinges upon the patient's speaking time. Instead, in line with earlier CA research, their participation is jointly negotiated and managed by the companions themselves, the doctor, and the patient (P. Cahill & Papageorgiou, 2007a; Stivers, 2001; Tates & Meeuwesen, 2000; Tiitinen & Ruusuvuori, 2012). This thesis has also shown how, even when companions are speaking, they maintain an orientation to the patient as principal respondent (see also Tiitinen and Ruusuvouri, 2012). Treating companions as having a negative effect on patient-centeredness may be misguided, therefore, because even if they are speaking instead of the patient, they may be doing so only after having given the patient the opportunity to speak for themselves.

Companions were also shown, in chapter 5, to act as surrogates or advocates for the patient. In the treatment discussion phase, for example, companions took the initiative to facilitate conversation about medication, and to raise concerns where the patient is unable or unwilling to provide a response for themselves. These are similar to the behaviours (asking questions and raising concerns) described by Clayman et al. (2005) and Ellingson (2002) as facilitating decision-making and autonomy.

This thesis has thus painted an overall positive picture of companion participation, suggesting that they facilitate and support, rather than diminish and disrupt, patient-centeredness and autonomy. It is worth pointing out, however, that Clayman et al. (2005) and

Ellingson (2002) also saw making requests on the patient's behalf, asking questions about alternative treatments, and expressing and supporting patient's unwillingness for certain treatments as a form of advocacy. In this thesis, on the other hand, companions carrying out such actions were also shown to be nudging for outcomes that did not always align with the patient's own wishes. This means that companions were not always acting as patient advocates, instead displaying, on occasion, their own stake or opinion when it came to decision-making

3 Limitations and directions for future research

3.1 Limitations

One of this study's limitations is the use of secondary data that was collected for an earlier project. This meant I lacked ethnographic insight into the study site that I might have gained in collecting my own data, as well as losing valuable context. This also meant that the purposes for which the data were originally collected did always match my own. This was particularly apparent, for example, in how companions in some of the videos were out of frame, making it impossible to determine the direction of their gaze.

The nature of the original project also meant that the data were limited to both initial consultations and to a particular geographic region (northern England). This raises the question of the applicability of the findings to follow-up seizure clinic consultations and to other demographics. Furthermore, whilst there was a substantial number of patients (n=30) and companions (n=31) in the data set, the same cannot be said of the doctors (n=3). This means that if a doctor had a particular interactional style, especially when managing companion contributions, it may have been over-represented in both the data and the analysis (see Drew, Chatwin, & Collins, 2001).

Beyond these limitations within the data set, there is also the broader question of the extent to which the findings from this thesis can be generalised to clinical contexts outside the seizure clinic. This is especially true given that, again, patients in this environment are explicitly asked to bring along a third party who has witnessed their seizures. Other clinical contexts, though, are likely to have different expectations and attitudes towards the presence and participation of companions.

3.2 Directions for future research

There are some dimensions of companion interaction that went beyond the scope of this study and thus were left unexplored. For example, this study treated all companion-patient relationships equally, regardless of whether they were a husband and a wife, a child and a spouse, or two friends. A future study could take into account the specifics of the companion-patient relationship to examine what effect, if any, it has on the interaction. This would be particularly worth investigating in relation to the companion's orientation to the patient's rights as primary respondent, and whether the extent and form of this orientation changes depending on the nature of the relationship.

A similar lack of distinction was made when it came to patient and companion characteristics, with all parties being treated as equivalent regardless of gender or age. Given the literature on how such characteristics can influence the presence and participation of companions (Wolff et al., 2011, 2012), though, it would be useful for a future study to take them into account.

Aside from these general directions for future research, there are also specific aspects of individual analytic chapters that could be further developed. In the coding section of chapter 3, for example, I did not, when coding for invited companion contributions, distinguish between whether it was the patient or the doctor issuing the invitation. Nor, in cases where the companion volunteered, did I make a distinction based on *where* they chose to volunteer. Given that CA section of the chapter showed such distinctions to be meaningful and consequential, however, a future study could use a more detailed coding system that took them into account. This would allow for more detailed comparisons based on the frequency of these different types.

Chapter 5 discussed how companions could propose their own diagnostic theories by using common-sense logic to imply causation that could then be explicated by the doctor. This was discussed in a limited way and only in relation to medication. Given the potential importance of this phenomenon for our understanding of the companion role, however, future research could look at it more systematically as a topic unto itself.

Also worthy of further investigation is the touching phenomenon observed in chapter 6. That analysis was based on only a handful of cases which, as noted above, makes it hard to make strong claims about the function of companions' touching. Given that the companion's emotionally supportive role has been comparatively under-researched, however, it would be worth exploring touching with a larger data set in a wider array of contexts.

It has already been noted that much of the existing research on seizure clinic interactions (including the project from which the data for this thesis was taken (Robson, 2013)) has had a focus on diagnosis. This has included, most notably, the finding that the way in which patients talk about their seizures can be indicative of whether these seizures are epileptic or non-epileptic (Robson et al., 2016, 2012; Schwabe et al., 2008). In this thesis, I have touched upon the issue of diagnosis only in passing; mirroring this, previous research on seizure clinics has considered companion contributions only in passing (Robson, 2013; Robson, Drew & Reuber, 2016). Clearly, though, there is much overlap between these two topics, and many of the findings of this thesis (e.g. upgrading corrections, the companion's participation in treatment discussions) could be relevant for diagnosis. Further research could, therefore, look at companions and diagnosis in the seizure clinic in a more integrated way.

4 Conclusion

Companions in seizure clinic interactions are not superfluous to the interaction, and their role is not insignificant. Nor are they a passive or disinterested third party. Instead, they play a dynamic role in this environment, facilitating information-exchange, participating in decision-making, and providing emotional support to patients at delicate interactional moments. They play this role, moreover, in all phases of the consultation, and maintain a constant orientation to the patient's rights as principal respondent as they do so. While companions' agendas can sometimes be misaligned with those of the doctor or the patient, they overwhelmingly act as a facilitative, supportive, and overall positive presence in seizure clinic interactions.

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APPENDIX A:

Jefferson Transcription symbols.

Transcription key: Jefferson transcription (Hepburn & Bolden, 2017; Jefferson, 2004)

[ ]	Square brackets	Overlapping tack
(0.2)	Time in seconds in round brackets	Intervals of silence within or between talk. (measured in tenths of a second)
(.)	Full stop in round brackets	Recognisable as silence but too short to measure
=	Equals sign	no space between turns.
-	dash	Indicates a cut-off
.	Full stop	Closing intonation, not necessarily at the end of a sentence
,	Comma	Continuing intonation (may be at the end of a sentence)
?	Question mark	Not necessarily a question, Rising intonation
↑↓	Up or down arrows	Marked shift in pitch (up arrow=rise in pitch, down arrow=fall in pitch)
wo:rd	Colons	Extension of preceding sound e.g the "o" in Wo:rd
word	Underlined word, or part of word	Emphasis
WORD	Capital letters	Loud speech (relative to surrounding talk)
°word °	Degree signs	Quiet speech (relative to surrounding talk)
>word<	More than symbol and less than symbol.	Speech that is speeded up (relative to surrounding talk)
<word>	Less than symbol and More than symbol	Speech that is slowed down (relative to surrounding talk)
.hh	Full stop and h's	Audible inbreath (more h's the longer_
hh.	h's and full stop	Audible outbreath (more h's the longer)
Hah/huh/heh/		Laughter
Wor(h)d	h in brackets within a word	Laughter/breathiness within talk
£	Pound sign	Smiley voice
#	Hash sign	Croaky voice
~	tilde	Wobbly/waivering voice
( )	Empty brackets	Transcriber could not hear what was said
(word)	word(s) in round brackets	Transcriber is unsure of what was said, words in bracket are their best estimation
(word/otherword)	Word(s) slash word(s) in round brackets	Transcriber is unsure what was said, gives two or more alternative estimations.
((comment))	Double round brackets with word(s)	Transcriber comment or description, often describes non-verbal behaviour
Tch.		Tongue click

APPENDIX B:

Complete Extract 11 from chapter 5

Extract 11 full extract. [156: Parent:27.07] (Anything else you want to ask?)

Just before this extract starts the neurologist (Doc) has been explaining scans of the patient's brain. This has mostly been directed at the patient's father (Com).

```
Doc:  I Mean there ar:e=>its just< a couple of minor
      abnormalities in the brain as we:ll, there's this little
      dot her:e.
Com:  Mm hmm.
Doc:  Which is a tiny little abnormal blood vessel. .hh There's
      another one back he-°owh° (0.5) there's another back
      he:re.
Com:  Mm hmm.
      (0.5)
Doc:  E::r these are called cavernomas. um and I I think um
      they're probably just coincidental=There's another one
      the:re.
Com:  Mhm.
      (2.2)
Doc:  I would be surprised if they were relevant.
Com:  Right.
Doc:  But it's not impossible.
Com:  Right. .hh Would that suggest-I mean obviously g- >you
      know< given our experience with with Luke
      and the Madeloblastoma and and everything=obviously we're
      sort of quite sensitive to .hh the possibilities of other
      things developing.=So is that something that would need
      monitoring o:r?
Doc:  Er No cavernomas a:re quite common in a e:r in ordinary:
      healthy individuals.
Com:  Mhmm.
Doc:  a:h The only time you would get interested in them is if
      the:y u:m seemed to be associated with epilepsy. .hh U:m
      the:y a:re not tumours they're no[t t]hey don't=
Com:                                   [N o]
Doc:  =have any potential for growth.
Com:  Yeah.
Doc:  But u:m they can be a nuisance some- sometimes.
Com:  Yeah.
Doc:  Just occasionally they can bleed=for example.
Com:  Mm hmm.
Doc:  Cos they- the:y a:re just rather thin-wa:lled blood
      vessels. [U:m  ]
Com:           [Mm hm]m (0.6) It couldn't lead to mini-strokes
      or anything like that? [(   )]
Doc:                          [U::m ] hhh I- those aren't going
      to cause any problems.
Com:  No °no.°
Doc:  They're too small t[o (be)] of of significance
Com:                     [Yeah. ]
Com:  Mm hmm.
      (1.9)
(A1):  °mhm°
      (0.7)
Pat:  O[k a  y  ] yeah,
```

```
Com:   [anything]
Com:  anything else (.) you feel you want to ask
      Luke?
Pat:  U::m no no I think that's
      (0.2)
Com:  Do you want to ask a little bit more about the the
      medication, What what (0.2) cos it's (0.2) >you know<
      Doctor Fuller talked about <sedation> and wh[at-]
Pat:                                                [O:h] yes
      s[o r r y]
Com:   [>Little] bit (Little bit )adverse affects< with the
      medication as we:ll.
      (0.7)
Pat:  U::m,
Doc:  And we talked about feeling a bit [dope]y at high=
Pat:                                    [yeah]
Doc:  =doses =we talked abou:t ah the rash that you
      [might (le- le- you)] get an allergic reaction.
Pat:  {H m m   y  e  a  h ]
      (1.2)
Com:  Would there be an alternative if Luke found
      tha[t this-]
Doc:     [Lots of] alternatives.
Com:  Yeah.
Doc:  There are abo[ut  u]m (1.1) ten: alternative=
(?):              [(yeh)]
Doc:  =anti-epileptic drugs that you could actually try:, (1.0)
      um and the reason for choosing one rather than another is
      (0.3) er, really mainly experience.
Com:  Mm hmm.
Doc:  U:m (0.4) you know what what we fi:nd works best.
Com:  Yeah.
Doc:  Um so we choose Carbamazepine because it's got a
      long-term established safety record=which is important
      because you might be taking it for the rest of your life.
Pat:  All right.
Doc:  A:nd becau:se it er is effective.
Com:  Mm hmm.
      (0.7)
Doc:  Bu:t er if it's not tolerated then there are plenty of
      alternatives. [So y]ou might try Lamotrigine=
Com:                [yeah]
Doc:  =instead you might try: um (0.3) Phenytoin instead. (All)
      those are newer drugs.
Com:  Mm.
      (1.2)
Pat:  Okay yeah,
Com:  alri:ght?
      (0.8)
Pat:  Fine.
      (2.0)
Doc:  So >as I say< the most important thi:ng is (0.4)
      ho:w you use it (0.2) It co:mes in 200mg tablets,
Pat:  Mm hmm.
      (1.8)
Doc:  Um, and I'll ask them to give you sixty to
      start off with? (2.6) and I will write down some
      instructions.
Pat:  Right.
      (2.4)
Com:  How do you feel about taking the medication
```

```
112          Luke?
113   Pat:   F(h)ine.
114   Com:   Yeah? Okay,
115          (0.5)
116   Pat:   Yea:h_ (0.6) It's what I do anyway, so:. Hhm [heh hhm]
117   Com:                                               [Ha  hhm]
118          (0.6) hhm [hh]m
119   Pat:             [h[hm]  [heh]
120   Doc:               [°y]e:[s° ] °°right.°°
121          (7.4)
122   Com:   Is there a common level at which people begin to
123          experience sedation o:r,
124          (0.3)
125   Doc:   No::,=it's- so much dependent on your metabolism and
126          your size.
127   Com:   Mm.
128   Doc:   And I can't guess what you will experience (0.4) um
129          ((patient name)) um (0.8) you might be: extraordinarily
130          sensitive to the drugs=
131   Pat:    [mhmm]
132   Doc:   =[Or y]ou might be: really: completely insensitive to
133          [the drugs.]
134   Pat:   [Oh right Oka]y
135   Doc:   You can't tell by looking at people.
136   Pat:   #All right. (so)#
```

APPENDIX C:

Complete Extract 13 From Chapter 5.

Extract 13 [0080 : 6.42-end of video](I give him them at night-time)

```
Com1= Wife
Com2= Son.

01    Pat:  [(      on ).]
02    Doc:  [So you    We]nt on Keppra, (0.7) At two-fifty twice a
03          da:y (0.7) and felt drunk. (2.0) You're no:w on just two-
04          fifty milligra:ms dai:ly. And is that making you sleepy?
05          (0.8)
06    Com1: I g[ive him them at ni:ght-ti:me.]
07    Pat:     [I   c a n -  I   c a n   slee]p all right=don't I?
08          (0.8)
09    Com1: Someti(h)mes.
10          (1.2)
11    Doc:  But probably it's not- But you've had a recent attack
12          >haven't you?< So it's probably not doing enough really.
13    Pat:  (No.)
14    Doc:  °tch.° Okay, Well I would suggest that we u:m change it
15          to some other medication.
16    Pat:  Mm.
17          (0.3)
18    Doc:  U:m and see how you get on with that.
19    Pat:  Yeah.
20    Com1: °(yeah)°
21          (1.7)
22    Doc:  So I'll, I think we'll swap you to: Lamotrigine which
23          should be well tolerated.
24          (1.7)
25    Com2: We- >we did actually< mention that to er <((doctor's
26          name))>,
27    Doc:  Yeah.
28    Com2: Y- y- you know. An an alternative to thee (0.2) er the
29          one that (0.2) er made him feel drunk.
30    Doc:  ((Sneezes)) Excuse me:,
31          (0.2)
32    Pat:  Lower dosage [(      )]
33    Doc:               [ Yea::h ] I thin[k I thi]nk he >I mean<=
34    (  ):                             [ hmm::.]
35    Doc:  =I'm su:re he's right in waiting for what we have to say:.
36    Com2: >Yeah ye[ah<]
37    Com1:         [>Tha]t that's what he's saying< he says he'd
38          ra:the:r it come fro[m you.
39    Doc:                      [I I >you know< he'd go:ne a a a step
40          further than most GP's in ringing us and
41          w[orking out where t]o start.
42    Com2:  [Yeah, yeah.]
43    Doc:  >I mean< it's unfortunate that Keppra didn't suit you cos 44
            it does suit most people.
45    Pat:  Ye[ah, ] ye[ah.
46    Com2:   [mhmm]
47    Doc:             [An]d that's just unfortunate really:.
48           [ So     um ] I think u:m >you know< I entirely=
49    (Pat): [ yeah yeah,]
50    Doc:  = understand where he's coming f[rom.]
```

```
Com2:                                  [>Yea]:h yeah<
Doc:  He he he'd done the job really:.
Com2: So the the the ne:w drug that you're er
       [once you']ve prescribed.
Doc:   [  Yeah.  ]
Com2: What e:r side effects should we be looking for?
Dox:  U:m. It's normally fairly well tolerated,
Com2: Right.
Doc:  When you first start it, there's a: risk of rashes,
Com2: Ri[ght.]
Doc:    [ So ] we'll start things off slowly and build it up.
Com2: Mm hmm.
Doc:  U::m .hhh Headache:s tummy upsets u::m (0.6) sleepiness
      is less common with it,
      (0.2)
Com2: Right.
Doc:  Sometimes on the higher doses in fact it causes problems
      with sleep rather than sleep>but I mean< with any of them
      you can get sleepiness, but it's [mu-] it's less likely.
Com2:                                  [( )]
Com2: Yeah<.
Doc:  So those are the sort of thi:ngs um are the are most
      common.
Com2: Yeah<.
      (2.7)
Doc:  With any of our tablets, they're not addictive. So if
      they cause problems you drop them back down again.
      (17.4) (( doctor writing))
Doc:  So over the next um (.) eight weeks I want you to
      increase it to a hundred milligrams and we'll see where
      we get to with that.
Pat:  #mm
Doc:  U::m (8.8) .hh Now do you have any questions at all?
      (1.8)
Pat:  >Have any< what=questions?
Doc:  Yeah<.
      (0.7)
Pat:  No not really.
      (4.3)
Doc:  When you went in in u:m December did they c- repeat your
      sca:n?
      (0.8)
Com1: Er yes they did.
      (0.7)
Doc:  I'll get a copy of that.=And they said there was no:
      other changes?
Com2: No.
Doc:  Fine. Okay so that's a pla:n for you:. (0.2) So wee:ks
      one and two=twenty fi::ve. Three and four=fifty (.) Five
      and six=seventy fi:ve .hh Eight and ni- ah >seven and
      eight< a hundred,
      (0.4)
Com2: Is is one tablet twenty five grams.
Doc:  Yes.
Com2: Milligrams
Doc:  A- as you build up there is a hundred milligram tablet
      [even]tually:. So u:m (0.4)[ you] can: settle=
Com2: [Right.]                   [yeah]
Doc:  =on one tablet. (0.4) The seizures have not been very
      frequent anyway: so I think >you know< let's see how
```

111 things go:. I-, I'll let your doctor kno:w.=I'll say that 112
if there are any problems give me a ri:ng.
113 Com2: Right.
114 Pat: (I fear) I'm a bit o:ld-fashioned and er
115 Doc: Yes?
116 Pat: I told ((doctor's name)) this I said I don't believe in
117 taking tablets .hhh I'd ra, rather take 'em (( )).
118 Doc: Yes.
119 Pat: (( )) so he's well, he's always ((aware of that?)).hh
120 He says "Yes, I'm awa:re of that and thank you very much"
121 (0.6) But I've got a, a poo:rly knee and er these
122 t[able]ts are giving me paranoia aren't they? (0.8)=
123 Com1: [( )]
124 Pat: =(when you've got annoying) tablets.
125 Doc: Yea::h I appreciate that. I- I think it'll be good to
126 control these attacks. If you rea:lly object to taking
127 them that's entirely up to you rea:lly.
128 Pat: Well that's what ((doctor[r's name))] said that didn't
129 he?
130 Doc: [U : : m]
131 Com1: Mm yeah.
132 (0.7)
133 Pat: ("It's) for your benefit". I says "Yes I'm aware of
134 that" (0.9) But er, I, I'm n[ot that kee:n] I'm not very=
135 (Com2): [( )]
135 Pat: =keen at taking them.
136 (0.4)
137 Doc: Well we are replacing one tablet with another. S[o: it]s=
138 Pat: [Yeah.]
139 Doc: =At the end of the da:y I- >I mean< and you can stop the
140 Keppra he:re a af- after a month.
141 (4.0)
142 Com1: Right.
143 Doc: Okay?
144 Com1: Mm.
145 (0.8)
147 Doc: (d- you going)to keep that?
148 Com1: Right.[( )]
149 Doc: [Now I]'ll give you a prescription for these new
150 tablets. You'll need to pop upstairs for tho:se.
151 (5.1)
152 Com2: S- so this er (.) new drug jus: just to contro:l the: e:r
153 focal seizures.
154 Doc: Ah And u:m and hopefully the bigger seizure:
155 ([N e v]er} to recu:r.
156 Com2: [Right.]
157 Doc: .hh I mean I- Unfortunately what one doe:s is build up
158 the dose.
159 Com2: Mm.
160 Doc: So if you're having infrequent seizures one's never
161 completely su:re that you've got on top of it.
162 Com2: Rig[ht.
163 Pat: [(oh [well)]
164 Doc: [B a s]ically the longer you go without an
165 attack (0.3) the less l[ikely it is for it (to retur-)]
166 Pat: [That's (what) that's wha]t
167 We're looking for.=ain't it?
168 Doc: Absolutely. We- we're looking for not getting these
169 attacks, either sort.
170 Com2: mm hmm
171 Pat: I were I were e- d- dis- disappointed when that's

```
        happened >while we were< away. (0.1) I thought I'd done
        with them. (1.4) So obviously (    ) one left.
Com1: You're stopping that now and you're starting that (0.2)
        (      ).
        (0.6)
Doc:  Stopping the Keppra in a month:.
Com2: N[o.]
Com1:  [N- ]O:h (they're still so) he's got to take one of each
        then?
Doc:  Just while we build up the dose for Lamotrigine.
Com1: a:h °ri[ght.°
Doc:        [So in a month you can stop the blue tablet.
Com1: Ri[ g h t.]
Com2:   [(great)]
```

APPENDIX D:

Table of Case-by-Case Demographics.

Below is a table of known general demographic information for each of the consultations in the data set. This is provided to give context to specific extracts. The consultation ID should match with the ID number in each extract throughout this thesis.

Table D.0.1 Consultation Demographic information

Consultation ID	Patient gender	Companion Gender	Companion Relationship to patient	Diagnosis at 6 month follow-up*	Doctor	Patient Age Range
155	male	female	spouse	PNES	A	51-65
156	male	female	parent	EP	B	20-35
161	female	female	friend	EP	A	20-35
162	female	male	spouse	PNES	B	50-65
165	male	male	parent	EP	C	20-35
166	male	female	spouse	EP	A	51-65
167	female	male	spouse	PNES	B	35-50
169	male	female	spouse	PNES	B	35-50
170	female	male	spouse	PNES	B	35-50
173	female	female	parent	PNES	B	35-50
176	male	female	parent	PNES	B	20-35
177	male	male	care worker	PNES	B	35-50
178	male	female	spouse	EP	A	35-50
179	male	female	spouse	EP	A	51-65
184	male	female	spouse	EP	A	20-35
186	female	female	parent	probably EP	C	20-35
187	female	male	sibling	PNES	C	20-35
074	female	male	spouse	PNES/migraine	B	35-50
076	male	female	spouse	PNES/migraine	B	20-35
077	male	male	friend	PNES	B	51-65

079	female	male	spouse	ND	A	20-35
080**	male	female	spouse	EP	A	65+
		male	child			
083	female	female	parent	Faint	A	20-35
084	female	male	spouse	ND, Not EP	A	35-50
085	female	male	spouse	Faint	A	51-65
088	female	male	spouse	EP	A	20-35
089	male	female	spouse	EP	A	65+
090	male	female	spouse	EP	B	35-50
091	male	female	spouse	EP	C	65+
096	male	female	spouse	Faint	A	65+

*EP= Epilepsy, PNES= Non-epileptic seizures, ND=No Diagnosis

**080 has two companions.