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# A Study of Pragmatic Competence: International Medical Graduates' and Patients' Negotiation of the Treatment Phase of Medical Encounters

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A Study of Pragmatic Competence: International Medical

Graduates' and Patients' Negotiation of the Treatment Phase of

Medical Encounters


by


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A dissertation submitted in partial fulfillment
of the requirements for the degree of
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# DEDICATION

       I dedicate this dissertation to my mother, Barbara Birchmeier and husband, Mario. My mother witnessed the commencement of my doctoral studies, but with her passing in 2011 she did not get to share with me both the pains and joys of the dissertation process. Her enduring love, sacrifice, and support shaped me into the woman I am today. In honor of my mother's memory, I dedicate the writing of this dissertation to her.

       My husband, Mario encouraged me to start down the doctoral path, believed in me, and stuck with me through the bitter end. His ceaseless encouragement, countless sacrifices, and patience are found in every word of this dissertation. His never-ending support made this dissertation achievable. With this dedication I honor his selflessness, humanity, and love. Muito obrigado, meu Amor.

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# ABSTRACT

Despite advances in medical technologies, interpersonal communication remains the primary tool physicians use to exchange information, make diagnoses, and treat patients (Cameron & Williams, 1997; Groopman, 2007; Ong, de Haes, Hoos, & Lammes, 1995).  In the medical encounter effective communication between physician and patient is essential so that beneficial health and wellbeing outcomes are achieved for patients.  Taking a discourse analytic approach, this study examined interactions occurring between international medical graduate (IMG) residents, attending physicians, and patients during the treatment advice phase of the supervised medical encounter.   The aim of the study was to examine the co-constructed nature of the delivery and receipt of treatment advice and the ways in which physicians and patients managed interpersonal relations through the negotiated activity.  The theoretical framework of pragmatic competence was utilized to underpin the study.  Physician-patient interactions served as the primary data source.  Medical encounter interactions between five different IMG residents and 31 patients were observed and audio-recorded.  Observations and a post-medical encounter survey completed by patients served as secondary data sources.  The analysis of the data revealed that this medical speech activity embedded within the medical encounter was realized through the use of a variety of discourse strategies and contributions from multiple participants as they attended to the interpersonal and transactional goals associated with the delivery and receipt of treatment advice.  Findings provided insights into how multi-party discourse worked to jointly construct and negotiate treatment recommendations.  Findings indicated that IMG residents

utilized indirect advice giving strategies.  Additionally, both IMG residents and patients utilized

interrogatives in various ways to engage actively in the treatment decision-making process.

Finally, the data revealed how the participants attended to each other's face needs as they worked

to enhance, maintain, or challenge face through the dynamic process of negotiating relationships.

**CHAPTER ONE:  INTRODUCTION**

It can be said that the daily work carried out by medical practitioners is accomplished by and through communication (Atkinson; 1999). While sophisticated technologies have become commonplace in a variety of medical settings to diagnose and aid in treating patients, interpersonal communication still remains the primary tool health care professionals use to exchange information, make diagnoses, and treat patients (Cameron & Williams, 1997; Groopman, 2007; Ong, de Haes, Hoos, & Lammes, 1995).  As a consequence, effective communication remains at the heart of the health care profession (Sandberg, Paul, & Sandberg, 2009).

The communication skills required to become socialized into the profession, the medical institution, and everyday clinical discourse demands specialized education.  Early on, in undergraduate medical education programs in the U.S., students begin to learn about and practice interpersonal communication skills. Through a variety of methods, such as reading to texts[1], role playing with standardized patients (or other students, faculty, or simulation mannequins) serving as patients, shadowing physicians, and instruction in taking and writing up a history and physical examination, medical students are introduced to the basic communication skills of the profession and the skills required to interact with patients.  In this way, this emphasis early in medical school education serves not only as didactic lessons but also underscores the importance of effective communication within the medical profession.  To further underscore the importance of

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[1] For instance, at the institution where the research took place Coulehan and Block's (2006) *The Medical Interview: Mastering Skills for Clinical Practice* is used in a course to teach medical students interpersonal communication and interviewing skills.

effective communication skills, the Liaison Committee on Medical Education (LCME), the accreditation body for undergraduate medical education in the U.S., requires that a medical education curriculum "include specific instruction in communication skills as they relate to physician responsibilities" (Liaison Committee on Medical Education, 2012, p. 10). Furthermore, starting in 2014 the Association of American Medical Colleges (AAMC) established a set of 13 core entrustable professional activities (EPAs) and critical competencies, which every U.S. graduating medical student should be expected to perform prior to entering residency. Interpersonal communication skills and professionalism competencies are integrated throughout the core EPAs and serve as critical components of a supervising physician's entrustment decision (Association of American Medical Colleges, 2014).

While most U.S. medical students receive some practical, hands-on clinical experience through short rotations (some rotations are two to three months long) at teaching hospitals or other clinical care settings, the real practice begins once medical students enter a residency program and become interns/residents. This education period is known as graduate medical education. Residency or graduate medical education takes place in university-affiliated teaching institutions characterized as having a dual aim of providing patient care and physician training (Hobbs, 2004). It is during this residency period that residents get the opportunity to put to practice the skills they have learned, both clinical and communicative. During this time, which may vary from three to seven years depending on medical specialty, residents work full-time in various clinical settings (e.g., teaching hospital, local primary care clinic, a private practice), rotating through multiple assignments as a means to obtaining a breadth of experiences.

Similar to undergraduate medical education in the U.S., an accreditation body known as the Accreditation Council of Graduate Medical Education (ACGME) oversees graduate medical

education.  The ACGME has established six core competencies at the graduate level in which residents must demonstrate progressive proficiency.  Starting in 2013 milestones, which are competency-based developmental outcomes, are being used to assess the knowledge, skills, attitudes, and performance of residents.  One of the six competencies on which residents are assessed is interpersonal communication.  The common program requirements, guidelines followed by all ACGME-accredited residency programs, related to interpersonal communication state: "Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals" (Accreditation Council of Graduate Medical Education, 2013).  Consequently, these program requirements and accreditation standards imposed on undergraduate and graduate medical education programs in the U.S. demonstrate the importance placed on effective communication skills.

However, one's ability to demonstrate effective communication skills that result in effective exchange of information depends on the individual resident.  That said, one group of residents who may be more likely to experience difficulty demonstrating effective communication skills are international medical graduates (IMGs; previously known as foreign medical graduates (FMGs)).  This population, IMG residents, forms the participant pool for this study.

**International Medical Graduates**

IMGs are individuals who have graduated from a medical school internationally but are completing their residency education in the U.S.  Nearly one-half of IMGs who enter a U.S. residency program come from countries where medical school instruction is conducted in a language other than English (Educational Commission of Foreign Medical Graduates Annual

Report (ECFMG), 2010). Consequently, when non-native English speaking IMGs arrive in the U.S. to commence their residency, they will be practicing medicine in English for the first time. It is this specific group of second language (L2) users, IMGs who are non-native English speakers, who are participants in this study. In the U.S. IMGs represent over 160 different countries; thus, they represent remarkably diverse sociocultural, linguistic, and educational backgrounds (Educational Commission of Foreign Medical Graduates Annual Report, 2010).

Prior to coming to the U.S., and to secure eligibility, incoming IMGs participate in a comprehensive certification process (including language and communication skills) administered by the ECFMG, which is an organization used by U.S. graduate medical education to certify international medical graduates. While this initial screening and certification process is a valuable first step in helping to ensure that incoming IMGs have adequate levels of competency (e.g., medical knowledge, clinical and interpersonal skills), it is only a small step as they prepare for the responsibilities they will encounter in the U.S. health care context (Hoekje, 2007).

The primary responsibility for educating and acclimating IMGs into the U.S. health care system lies within and through their experiences in the residency program. Within this learning environment, an emphasis is placed on practicing and developing the necessary clinical skills and competencies to master residency and become a fully competent physician who is able to function independently. While focusing on these requisite skills and competencies, IMGs oftentimes face additional professional, cultural, and linguistic hurdles because of their limited U.S. experience.

**Medical Discourse Socialization and Pragmatic Competence**

Arguably, the most weighty and significant challenges IMGs will face relate to their socialization into a new medical discourse community (Hoekje, 2007; Whelan, 2006). Language

socialization provides a useful approach to help explain how IMGs will acquire the knowledge, orientations, and practices enabling them to participate in their new discourse communities. Language socialization refers to the process by which newcomers to a social group (e.g., family, classmates, workmates) are exposed to and engage in language-mediated social activities to become active, competent members of a community (Schieffelin & Ochs, 1986; Ochs, 2000). Language plays an important role for it serves as both the means and the central goal of the socialization. The locus of socialization centers on novices' participation in activities with experts. Thereupon, through novice-expert interaction and collaboration, novices come to learn the linguistic resources and practices of the community.

Studies focused on second language acquisition have appropriated the language socialization approach to examine the potential link between L2 learning and sociocultural context. L2 socialization studies have examined how L2 users, through their engagement in activities with expert users, likely native or near-native speakers of the target language, come to learn, appropriate and, in some instances, resist a community's discourse practices (See Duff, 1995, 1996; Kanagy, 1999; Li, 2000; Morita, 2000, 2004 for examples of L2 socialization studies). Thus, for L2 users like IMGs, language skills will be shaped in part through the socialization process and by the culturally-specific activities in which they are used (Morita, 2000).

Consequently, IMGs' socialization into the medical discourse community entails double-duty, so to speak. Many discourse activities, such as interactions with patients and families, occur "frontstage", or within the public sphere of the workplace (Sarangi & Roberts, 1999, p. 21)[2]. Within these "frontstage" discourse activities, IMGs' competencies–clinical, linguistic,

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[2] Goffman (1959) introduced this performative-based metaphor to suggest that social life in general can be viewed as consisting of a frontstage and backstage. The notion of an audience, performing for or in front of an audience, and

interactional, and professional–are on full display. Away from public view, in the "backstage"

of the medical institution, a plethora of discourse activities, such as case logs, patient rounds, and

clinical as well as collegial talk also take place (Sarangi & Roberts, 1999, p. 22). Thus, it is

through these everyday medical discourse practices, taking place on both the "frontstage" and

"backstage" that IMGs linguistic, sociocultural, and professional knowledge are constructed,

tested, and legitimated.

Additionally, IMGs face the additional challenge of socializing into the local medical

institution as well as patient communities being served through their L2. Daily discourse

activities related to patient care involve learning the institutional, sociocultural, and linguistic

norms in the target language of the medical community. Furthermore, the need to become

socialized into the L2 community takes on an additional level of importance due to the pressure

to appear competent in a host of areas and to a number of stakeholders. As mentioned earlier,

residents, domestic and IMG alike, are expected to demonstrate competency in multiple areas

(e.g., interpersonal communication, medical knowledge). Therefore, the pressure to "perform"

in the L2 becomes all that more great.

Turning to the focus of this study, IMG residents' socialization success, or lack thereof, is

ultimately associated with the essential notion of communicative competence. While conducting

the aforementioned "frontstage" and "backstage" discourse activities, IMG residents demonstrate

communicative competence through their abilities to use language in socially appropriate ways.

In other words, demonstrating communicative competence entails not only knowing the

grammatical and lexico-syntactic rules and structures of a language but it also requires

familiarity with the sociocultural rules of appropriate language use. In the fields of applied

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the use of formal/informal communication styles are central to the discussion of the different stages. Sarangi and
Roberts (1999) utilized the "frontstage" and "backstage" metaphors to differentiate discourse activities based on
where they are performed within an institution (p. 20).

linguistics and second language acquisition (SLA), this notion of socially appropriate language use has come to be called pragmatic competence and is the theoretical focus of this study.

According to Bardovi-Harlig and Hartford (1990),

"the ability to use utterances that are appropriate both for a given speech event and for the participants in that event is part of a speaker's pragmatic competence. Context-specific pragmatic knowledge is particularly troublesome even for linguistically competent nonnative speakers: it is their level of pragmatic competence and not their grammatical competence that distinguishes them from native speakers" (p. 468).

As this description details, pragmatic competence entails the ability to use linguistic resources that are appropriate for specific contexts and situations. Bardovi-Harlig and Hartford's (1990) description highlights the multiple dimensions of context–both situations and speaker/listener roles–and the fluidity of pragmatic knowledge interlocutors must attend to during interactions. Consequently, for L2 users pragmatic competence entails a convergence of abilities and knowledge. That is, in order to be judged pragmatically competent during interactions, L2 users require sufficient linguistic skills in the target language and adequate knowledge of the sociocultural norms of situations in the target culture in order to function similar to native speakers. As Bardovi-Harlig and Hartford (1990) assert, it is pragmatic not grammatical competence that typically exposes an advanced L2 user as a non-native speaker of the target language.

It is clear that IMG residents will have the opportunity to put their pragmatic competence to the test, so to speak, in a multitude of medical speech events or activity types. One such activity in which IMG residents' pragmatic competence is on display is the medical encounter. During this medical activity IMG residents interact with patients attending to both the

communicative functions of the activity and the interpersonal relations in order to learn about patients' illnesses, determine diagnoses, and possibly develop treatment plans. Thus, during these patient interactions IMG residents' pragmatic abilities are on full display as they work jointly with patients to co-construct the medical problem and address possible future outcome. Consequently, as an essential speech activity of the discourse of medicine and an activity in which IMG residents participate, the medical encounter, including a brief overview of the literature, will be explored in the next section.

**The Medical Encounter**

As previously discussed, the discourse of medicine is comprised of a multitude of communicative exchanges, or activity types, amongst various participants, both clinical and non-clinical, and using different genres that occur in a variety of medical settings. This study focuses on one type of medical activity type: physician-patient interactions in the medical encounter. The medical encounter is the typical office visit, in layperson's terms, where one seeks physician care due to illness or to maintain health. A sizable body of literature has been amassed concerning this one type of medical activity. In particular, physicians have received primary focus as compared to other health care professionals, such as nurses, physical or occupational therapists, or psychologists (Candlin & Candlin, 2003)[3]. However, based on a review of the literature, IMG residents have not been extensively studied in this context.

Over the years, analyses into the nature of the medical encounter discourse have led scholars to classify it as a particular genre (Ainsworth-Vaughn, 2001; ten Have, 1989). Frequently, scholars have attempted to classify medical encounter discourse as either an interview or a conversation. The phrases "medical encounters" and "medical interviews" are

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[3] Notable exceptions are Nguyen's (2006, 2012) examination of pharmacists' interactions with clients and Kovarsky and Walsh's (2011) examination of speech language pathologists.

used interchangeably in the literature to refer to the same phenomenon. In this sense, an interview genre with its question-answer format can be used to characterize physician-patient interactions. On the other hand, scholars have found features of conversation, such as its sequential organization, the use of certain discourse features (e.g., overlapping speech, interruptions, use of prefacing discourse markers *well* or *uhm* to start a sentence) or the use of small talk, in medical encounters. As well, other scholars have examined the use of narrative or stories (see Halkowski, 2006), "often cited as archetypal conversational speech activities" (Ainsworth-Vaughn, 2001, p. 457) as ways for patients to realize their illness or ways for physicians to talk about diagnoses. While some of these interview or conversational features may be found in medical encounter interactions, Ainsworth-Vaughn (2001) warns against exclusively trying to use either genre to characterize medical encounters. While these genre distinctions may be helpful in identifying some of the salient features of the medical encounter, Ainsworth-Vaughn (2001) tells us that "encounters exist on a continuum between interrogation, as described in Mishler (1984), and friendly conversation" (p. 458).

Moreover, research on the discourse of medical encounters has examined the activity type in two primary ways. One approach has been to examine the medical encounter and its inherent discourse types as a constitutive whole (e.g., Frankel, 1984; Mishler, 1984; Shuy, 1976; Tannen & Wallat, 1987). For example, in Mishler's *The Discourse of Medicine: Dialectics of Interviews* an analysis of medical encounter transcripts characterizes the "voice of medicine and voice of the lifeworld" (p. 14), which exemplify the different ways of conceptualizing and understanding patients' medical problems. A second approach to examining the medical encounter is to segment the constitutive whole into parts, or specialized, distinct structural phases. In this way, a particular phase or episode of the medical encounter becomes the primary research

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focus.  Several researchers (e.g., Byrne & Long, 1976; Robinson, 2003; ten Have, 1989; Waitzkin, 1991) have proposed models for the medical encounter and the distinct phases that comprise it.  Overall, the models these researchers have put forth to describe the organizational structure of the medical encounter are relatively similar.  Thus, the medical encounter can be divided into six phases (see Figure 1):
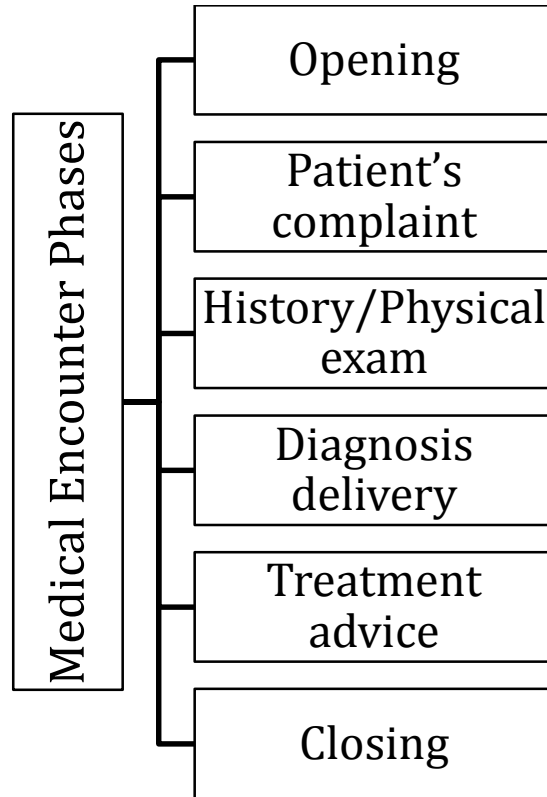


Figure 1 Medical Encounter Phases

ten Have (1989) called the medical encounter a specialized medical genre comprised of these distinct phases to which both patients and physicians orient and participate in (p. 115).  It is a recognizable genre; most adults who have visited a doctor in the U.S. would recognize this type of activity as one in which they have participated.  Thus, it can be said that the medical encounter

is a ritualized (speech) activity and is one of the many activities, which comprise the discourse practices of medicine (Sarangi & Candlin, 2011).

A subject matter that has been pursued by researchers who study the medical encounter is asymmetry between physicians and patients. Many scholars have written about physician-patient asymmetrical relationships and physician's exercise of authority (e.g. Frankel, 1984; Maynard, 1991; Mishler, 1984; ten Have, 1991). The notion of asymmetry and ceding of authority is based, in part, on the physician's expert, technical knowledge, rooted in years of formal, certified education and reified by the medical institution (Sarangi & Candlin, 2011; Heritage & Clayman, 2010). In contrast, patients typically bring a laypersons' knowledge about their illness specifically and clinical knowledge in general to the medical encounter. Therefore, given their different roles and resources, physicians and patients represent opposite ends of the medical social structure continuum. Thus, through the lens of the medical institution, a power differential exists between physicians and patients.

In an effort to create balance in this power differential, in recent years the U.S. healthcare system has evolved to consider the patients as partners in their own care; consequently, a patient-centered model of care has emerged (Emmanuel & Emmanuel, 1992; Mead & Bower, 2000). Accompanying this emergence, patients are moving from a passive to an active role concerning the status of their health (Sharf & Street, 1997). This active participation is facilitated, in part, by an abundance of medical information found on the internet leading to new labels such as "health consumer" or "health citizen" (Lambert et al., 1997; Sharf & Street, 1997).

The enactment of institutional roles of physician and patient can be observed through the talk produced in the medical encounter. Thus, the notion of asymmetry has important consequences for interactions. To shed light on how this asymmetrical relationship is actually

produced in and through the physician-patient interaction, ten Have (1991) examined the structure and sequences of talk in the medical encounter and showed how topic and task created asymmetry. In regard to the topic of the medical encounter, it is clear that the purpose of the visit is the patient's health and wellbeing, not the physician's. Thus, getting at the topic required the execution of a series of tasks that, according to ten Have (1991), involved "quite 'natural' interactional dominance by the physician enacted through questioning, investigating, and decision-making behavior, coupled with interactional submission by the patient, achieved through answering, accepting, and generally complying with the doctor's orders and suggestions" (p. 140). Though some researchers have demonstrated that patients' agency (Peräkylä, 2002) and withholding treatment acceptance (Stivers, 2005b, 2006) have contributed to a balancing of power between physicians and patients, the broad picture suggests that an asymmetrical relationship tends to exist in most cases.

Under the patient-centered model, the patient's perspective is considered. For instance, a more patient-centered model is enacted when patients are provided more latitude to explain illness and symptoms through, for instance, the use of open-ended questions. Moreover, the patient's perspective is also taken into consideration when decision-making is viewed as a negotiated process. Increased patient participation regarding health care matters has potentially consequential implications on the physician-patient relationship. Consequently, this shift in perspective has compelled researchers to design studies differently. Where researchers once focused only on the physicians' or patients' contributions to the interaction as isolated units, recently they have begun to take a co-constructive approach by viewing both parties' joint contributions in action (Heritage & Maynard, 2006; Jacoby & Ochs, 1995). Further, Heritage and Maynard (2006) state "analyzing co-construction is a direct research embodiment of patient-

centeredness, because it includes physicians and patients both within the nexus of communication through which medicine is practiced" (p. 20). Thus, through the analysis of the co-constructed interaction between physician and patient, instantiations of asymmetry will be revealed (or not) through the turn-by-turn design of the conversation. This study follows this co-construction approach and considers both IMG resident and patient participation in the interaction. Furthermore, the review of the literature suggests that the role of power as it is indexed through the medical encounter talk requires consideration and further examination.

**The Medical Encounter Phases**

This next section of the introduction offers the reader some contextualization by providing an overview of the six phases of the medical encounter. The review is limited to studies in which a discourse approach is utilized to examine the physician-patient interactions. This discourse analytic approach is in line with the approach that is used in this study. To organize this section, the presentation is ordered sequentially from the opening to the closing of the medical encounter.

Various scholars and researchers representing not only health sciences fields but also disciplines such as sociology (e.g., Boyd & Heritage, 2006; Heath, 1992; Mishler, 1984; Peräkylä, 1998, 2002; ten Have, 1989, 2001; West 2006), communications (Halkowski, 2006; Robinson, 2001, 2003, 2006), and applied linguistics (e.g., Cordella & Musgrave, 2009; Coupland, Robinson, & Coupland, 1994; Erickson & Rittenberg, 1987; Hobbs, 2004) have analyzed the phases. Much of the work done in this area has been examined through the theoretical and methodological framework of conversation analysis. The body of work that has been amassed has revealed the design, sequential structure, and turn-taking approaches that characterize the physician-patient interactions across the phases.

**Openings.**

The opening of a medical encounter (i.e., the time when the physician enters the exam or hospital room, asks a *How are you?*-type question and reads the chart) sets the stage for how the rest of the encounter will proceed. Specifically, the format and design of the opening-eliciting question can shape the content and design of the patient's answer and subsequent presentation of the medical problem (Robinson, 2006). In a seminal sociolinguistic study, Coupland, Robinson, and Coupland (1994) examined the opening sequences of the medical encounter to demonstrate how medical encounter openings can be used to establish medical or social discursive frames. That is to say, the opening question and answer sequence between the patient and physician may remain more socio-relational, using phatic communication (Malinowski, 1923) to exchange pleasantries and small talk before moving onto the medical matter at hand. Conversely, the opening question and answer sequence between the patient and physician may move the talk right into the medical domain. In their study of physician-geriatric patient interactions, Coupland et al. (1994) presented several different examples of *How are you?* question-answer sequences. They found that responses to *How are you?*-type elicitations were not predictable but many of their examples demonstrated how socio-relational talk was sustained for at least a portion of the opening frame before talk moved into the medical frame (p. 118-119).

Robinson (2006) expanded this area of research and found that different question formations were used for different physician visit reasons. He found three different reasons for physician visits: new concern, follow-up concern, and chronic-routine concern (p. 23). New concerns elicited from the physician question formations, such as *What can I do for you today?*, *What brings you into see me?* and *How can I help you today?* In follow-up concern visits, physicians may use such questions as *How is it?* or *How are you feeling?* Chronic-routine

concerns may elicit *What's new?* from the physician when asking the patient the status of their recurring problem. Robinson went on to show how an incongruent visit type-question format could lead to different and often inappropriate actions on the part of the patient. Ultimately, however, the physician is held accountable for the inappropriate design of the question (p. 46).

These research studies demonstrate how patients and physicians negotiate and co-construct the opening moves of a medical encounter. The physician starts the negotiation with the opening question. Accordingly, the question's content and formation set the interaction into a socio-relational or biomedical frame of talk. In other words, question formulations of a more general manner, such as *How are you?,* lead to a socio-relational response by the patient. In these instances, the patient decided in which direction to take the talk. Whereas specifically directed questions, such as *How is it?,* leave the patient little choice but to move the talk into the biomedical frame.

### Patient's complaint.

After the physician's opening *How may I help you today?* or *What brings you here today?* is completed, the patient may begin a presentation of the symptoms, illness, or problems that brings her or him to see the physician. Patients' problems can be categorized into two types: known problems and unknown problems. Known problems are routine illnesses such as influenza or a sore throat. With these types of routine illnesses patients need to convince themselves that the symptoms are real enough to make a visit to the physician's office. In other words, are the symptoms worthy of concern or, as Heritage and Robinson (2006) termed them, a "doctorable" (p. 58) medical concern? The presentations of these types of known routine illnesses were characterized by symptom descriptions with the patient communicating the symptomatic details of the illness, with variable levels of explanation, to the physician.

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Sometimes in this phase the patient attempted a self-diagnosis (Heritage & Clayman, 2010).

Another type of known problem is recurring illness, such as diabetes or high blood pressure, which cause a patient to see a physician on a regular basis. With these types of recurring problems, in most cases, they are "unconditionally legitimate illnesses" (Heritage & Clayman, 2010, p. 124); that is, a previous diagnosis grants legitimacy to the visit. As such, the physician typically knows the nature of the problem, thus the patient's presentation of the problem is generally short and succinct.

Unknown problems, on the other hand, are illnesses or problems that cause pain, hurt, or tenderness but the patient has no name to give these physical sensations. Consequently, with unknown problems patients need to figure out how to name and describe the symptoms to the physician. Unknown problem presentations are sometimes characterized by the use of narrative. The narrative may contain historical information, problem duration, and may also focus on a turning point – an episode that compelled the patient to come in for a visit (Heritage & Clayman, 2010).

This literature reveals that a patient's presentation of either of these types of problems, known and unknown, is different. For instance, a recurring problem is characterized by short descriptions and turns of talk that use specific vocabulary (Heritage & Clayman, 2010; Heritage & Robinson, 2006). In contrast, the presentation of an unknown problem may be long and the patient may have some difficulty naming symptoms. What remains clear about this section of the medical encounter is that the "presentation of the problem is unavoidably interconnected with what Goffman (1959) called the 'presentation of self'" (Heritage & Clayman, 2010, p. 133). In other words, a patient's character and moral identity is on the line, so to speak, when making a visit to the physician's office for symptoms or an illness that is nebulous and difficult to

describe. The patient is in a position to save face by convincing the physician that the problem being presented is a "doctorable" medical concern.

**History taking and/or physical examination.**

Physicians are trained to gather additional information about patients' presenting complaints. Importantly, this additional information not only pertains to the current medical problem (i.e., the reason for the visit) but also any preexisting conditions, current medications, family history, and psychosocial considerations (Boyd & Heritage, 2006). This information-gathering activity typically occurs during the history taking and physical examination phase, which is structured by a series of questions and answers (Heritage & Clayman, 2010; Robinson, 2003). In this way, this phase of the medical encounter is structured more like an interview than a conversation (Jones, 2001). For instance, in her analysis Jones (2001) found that during the history-taking phase physicians tended not to offer third turn assessments after a patient responses, a common feature found in conversation. Rather, they used acknowledgement tokens (*mhm*, *uh uh*), nonresponses, or moved right into the next question (p. 136).

Research on this phase of the medical encounter has focused on the sequencing, design, and features of questions and answers. Researchers have observed that question-answer sequences, at a minimum, are characterized by three features: (a) questions establish a particular topical agenda requiring an actionable response, (b) they embody presuppositions about various aspects of a patient's health, and (c) they are designed to incorporate preferences which invite or favor one type of answer over another. When answering physicians' questions, patients may formulate their responses to accept or resist any or all of these question features. In addition, although physicians have choices when it comes to how to formulate their questions, it has been found they typically design their questions optimally so as to receive a positive or "no problems"

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outcome in response. (Boyd & Heritage, 2006; Heritage, 2002; Heritage & Clayman, 2010). For instance, the following series of questions and answers illustrate this optimal design:

EXCERPT 1

PHY:  Is your blood pressure normal?

PAT:  Yeah

PHY:  Any shortness of breath?

PAT:  Uhm, no

PHY:   Are you able to walk up a flight of stairs okay?

PAT:  Yes

The design of the first and third questions invite a "yes" response indicating there is "no problem" with the patient's blood pressure and their ability to do moderate physical activity. In contrast and in keeping with the positive outcome response, the negative design of question two, through the lexical choice "any", invites a "no" response from the patient.

Examining history-taking interviews that expand beyond question-answer sequences inviting restrictive yes/no responses, Stivers and Heritage (2001) explored extended patient responses–responses that volunteered more information than was requested. They found two types of extended responses–"expanded answers" and "narrative expansions"–that are more in line with ordinary conversation (p. 154). While "expanded answers" provided a response to the question and brief elaboration, "narrative expansions" enabled the patient "to build a progressive movement away from the agenda of the physician's question" (p. 155). According to Stivers and Heritage (2001), these responses functioned to accomplish a range of ancillary tasks; most significantly they revealed "various matters of significance, concern or preoccupation for the patient" (p. 179). In sum, research in this area reveals that history-taking tends to follow the

question-answer format of an interview. Physicians try to keep to a script, so to speak, and keep the encounter moving along a medically relevant path; therefore, they tend to offer few assessments of patients' newsworthy responses. However, evidence suggests that from time to time, patients choose to break free of this "sequential mold" to provide expanded answers to which the physician must attend (Stivers & Heritage, 2001, p. 151).

**Diagnosis delivery.**

ten Have (2001) provides a useful definition of diagnosis illustrating just how complex this phase of the encounter can be. That is,

"diagnosis, as a the *[sic]* activity of a professional expert, like a physician, involves a process of sorting out various possible interpretations or explanations by which a complex set of signs, either reported, observed, or measured, is reduced to a limited number of significations" (p. 252).

For the most part the literature on this phase of the medical encounter has focused on the ways in which physicians deliver diagnoses to patients. Concomitant with examining physicians' different diagnostic approaches, scholars have also examined how this phase highlights physicians' expert authority. Byrne and Long (1976) focused on the different styles used by doctors to announce the diagnosis. Authoritative styles were utilized most frequently.

Taking a co-construction approach, Heath (1992) examined both the verbal and non-verbal behavior of both doctors and patients while patients responded to the doctor's diagnosis. Heath noted the remarkable passivity of patients' responses and observed that many patients remained completely silent or, at most, offered brief acknowledgements. Thus, the physicians displayed and maintained authoritative control over the diagnosis delivery phase.

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In a Finnish context, Peräkylä (1998) showed the different ways physicians formulated deliveries of diagnoses to patients. He distinguished between three types of diagnostic deliveries: a plain assertion, diagnostic turns incorporating inexplicit references to the evidence, and diagnostic turns that explicate the evidence (p. 305-306). His analysis suggested that physicians maintained a balance between *authority* and *accountability*. Through the interactions, a balancing act between two potentially conflicting orientations evolved. That is, the physicians and patients oriented to the realm of physician medical reasoning and authority on the one hand and toward physicians' desires to treat themselves as accountable to patients' diagnostic evidential needs on the other hand.

A defining feature of the diagnosis delivery phase is the display of authority by physicians. Displays of authority occurred in the ways physicians delivered diagnoses. In addition, patients used silence and minimal responses to show deference to physicians' medical, expert authority. However, Peräkylä showed a more tempered display, which was achieved through a balance of authority and accountability.

**Treatment advice.**

As discussed above, the treatment advice phase receives primary focus in this study. As evidenced by the medical encounter model, the treatment advice phase typically occurs after the point at which the physician offers up her/his diagnosis based on the patient's presenting symptoms. The physician's diagnostic reasoning and subsequent treatment advice is based on the patient's presenting symptoms, the patient's explication of these symptoms, the results of the physician's history-taking and examination, and the physician's medical knowledge and past experience (Heritage & Clayman, 2010). It is typically dispensed in medical encounters when the physician's diagnosis requires a subsequent course of action on the part of the patient.

Consequently, not all medical encounters contain a treatment advice phase. For example, a wellness visit consisting of an overall physical examination may require no course of treatment, especially if no physical problems are found during the examination. Consequently, in these cases the medical encounter moves directly to the closing phase (see below for description of Closing phase).

Interestingly, Heritage and Clayman (2010) noted differences between the diagnosis and the treatment phases in regard to physician-patient interactions and these interactional effects on the physician-patient relationship. The diagnosis delivery phase is characterized by little or minimal response by the patient as the physician gives the patient diagnosis. Therefore, this interactional chasm, characterized by maximum physician talk and minimal patient talk, has consequential effects on the physician-patient relationship. As Heritage and Clayman (2010) suggest, "the act of diagnosis remains a fulcrum in the exercise of medical authority" (p. 179) and promotes an asymmetrical relationship.

In contrast and as will be demonstrated in chapter two (See "Empirical studies focused on the treatment advice phase of the medical encounter" section) and Chapter three, the treatment advice phase contains noticeably more interaction and is characterized by more patient response. In this way, the treatment advice phase offers more potential for negotiation between IMG residents and patients. In addition, medical authority, and as a consequence the physician-patient relationship is "compromised by a tacit bargaining process, in which the perception that patients may become dissatisfied with their medical care may outweigh the exercise of clinical judgment" (Heritage & Clayman, 2010, p. 179).

As mentioned previously, this study takes a co-constructive approach to examine the ways in which IMG residents and patients jointly create the treatment advice phase of the

medical encounter.  Previous studies have shown that the conversational sequence defining the

treatment advice phase can be realized in different ways.  In what follows I will provide two

examples to demonstrate how the treatment advice phase is realized.  The first example shows

how the physician offers treatment to a patient, in this case a child who is diagnosed with a cold

and the way the patient's father responds:

> EXCERPT 2
>
> PHY:  So wha- what I can do is give her uhm cough medication has a little bit of
>
> combination of uhm decongestant and also clearing up the
>
> DAD:  Oh okay
>
> PHY:  nose, dry it up up little bit so at night she can sleep a little better
>
> DAD:  Okay
>
> (Adapted from Stivers, 2005a)

This excerpt shows that the physician proposes treating the cold by having the child take cough

medicine.  The form this physician uses to offer treatment takes a wh-cleft construction followed

by a first-person pronoun and a modal declarative in the formulation of "what I can do is…",

thereby leaving the relevant and informational aspect of the treatment plan, the "cough

medication" and "decongestant", at the end of the sentence.  This construction allows the

patient's father to attend to this new and unfamiliar information.  The father responds by using

an agreement token "okay".  In this next example, the physician recommends antibiotics for an

ear infection.

> EXCERPT 3
>
> PHY:  Ah what I'd like to do is put you on some antibiotics and uh give you a
>
> decongestant.  See if we can dry out the pressure

PAT:   (slight head nod)

PHY:   Uhm it is going to interfere with who you are for a while that will probably last

for about two to three weeks, what I would tell you is don't go up to Big Bear

don't do any uh airplane trips (0.4 sec pause)

PAT:   (slight head nod)

PHY:   Cuz it'll be uh kind of uncomfortable for you if you do that

PAT:   That's fine

(Adapted from Koenig, 2008)

The syntactic structure of the treatment recommendation formulation used in excerpt 3 is similar

to the structure used in excerpt 2.  However, excerpt 3 differs from excerpt 2 in that it takes

several turns by the physician to convince the patient that this is an adequate course of action.

The physician provided different explanations about health outcomes, possible side effects, and

how the antibiotics will affect the patient's life style before the patient verbally acknowledges

and accepts the treatment recommendation with "that's fine".

Much of the research on the treatment advice phase (conducted by one researcher, Tanya

Stivers) has focused on interactions that involve physicians and parents of ill children.

Consequently, a paucity of evidence exists about how physicians, let alone IMG residents, offer

treatment to adult patients.  Thus, this study fills two important gaps as regard the interactants:

(a) on the physician side of the encounter, the physicians will be IMG residents, and (b) the

patient population will primarily consist of adults.

**Closings.**

Some research has been conducted on the closings of medical encounters (Heath, 1986;

Robinson, 2001; West, 2006; White, Levinson, & Roter, 1994), that is, the point in time or the

events leading up to when the patient and the physician say their farewells and depart company. This phase of the medical encounter has received attention due in part to physicians' complaints about the "by the way" syndrome (West, 2006; White et al., 1994) in which patients begin to talk about additional physical ailments in the closing moments of the medical visit.

Research evidence seems to suggest that these "by the way" patient moments are theory, hunches or simple anecdotal evidence. In other words, neither empirical study nor talk-in-action investigations into physician-patient interactions back up this claim. White et al. (1994) found that 21% of patients raised additional symptoms or complaints in the closing section of the medical visit. Furthermore, in their analysis of closing conversations between physicians and patients, Heath (1986) and West (2006) found rare instances of this "by the way" phenomenon. This evidence suggests that either this "by the way" syndrome is a figment in physicians' imaginations or the raising of additional medical problems is occurring in another phase of the medical encounter, likely prior to the closing.

This section provided a brief review of the literature focused on the different phases of the medical encounter. Furthermore, the purpose of the section was to provide some contextualized background information to the reader explicating the different interactional features of each phase. Viewed holistically, the literature demonstrates how each phase, and the physician-patient interactions comprising it, is designed differently. Moreover, it is not to be assumed that the medical encounter always follows this logical sequence or that all constituent parts are found in physician-patient interactions. Some activities will be varied or omitted entirely.

**Statement of Problem**

Institutional discourse, constructed and shaped by the speech community members that comprise it, is necessarily a study in pragmatics (Widdowson, 1998). The organizational rituals, modes, manners, conventions of communicating, and the knowledge of the language used are constructed and instantiated by the members of the institutional community, thus making the discourse highly context-dependent. Consequently, as new members enter an institutional discourse community, an active process of showing, telling, learning, practicing, and incorporating the discursive practices occurs as the new member is socialized into the community. But, importantly, this institutional acculturation process is constrained by the sociocultural norms and practices of the institution in terms of how things are said, to whom, where, and when (Sarangi & Candlin, 2011). For instance, as noted previously in this chapter, evidence suggests that asymmetrical physician-patient roles and a question-answer format constrain the institutional practice of the medical encounter. Thus, learning what is considered appropriate within the normalizing constraints of an institution is an exercise in trial and error, patience, and an active participation in the process.

With this in mind, turning to this study, IMG residents may be considered new members who are entering the discourse community of the medical profession in the U.S. As described above, with this new membership is entailed the additional "pragmatic" responsibility of learning, adapting to, and incorporating the socially and institutionally appropriate ways of communicating within the medical discourse community. For some IMG residents, this may be a heavy and burdensome responsibility. It is possible that some IMG residents, as L2 English users, may be linguistically and grammatically competent but their pragmatic abilities may not be at the same level of pragmatic competence (See Bardovi-Harlig, 1999; Kasper & Rose, 2002

for a review of the relationship between grammatical and pragmatic competence).  Consequently, this mismatch in competencies may lead to miscommunication, communication breakdown or being perceived as assertive or even socially awkward.

Additionally, IMG residents represent diverse sociocultural backgrounds.  Therefore, it is likely that their sociocultural backgrounds and educational experiences will impact ways in which they view and conduct interactions with patients.  Research indicates that some IMG residents experience difficulties adapting to the ways in which physician-patient interactions are conducted in the U.S (Dorgan, Lang, Floyd, & Kemp, 2009; Hall, Keely, Dojeiji, Byszewski, & Marks, 2004).  For example, some IMG residents have reported difficulties delivering diagnosis and treatment advice directly to the patient due to the fact that from their cultural perspective this news should be delivered to a family member (Hall et al., 2004; Jain & Krieger, 2011).  Additionally, as regard asymmetrical relationships between physicians and patients, IMG residents have reported that patients should directly follow advice of physicians and not question or challenge their authority (Dorgan et al., 2009; Erickson & Rittenberg, 1987; Jain & Krieger, 2011; Searight & Gafford, 2006).  Therefore, it is possible some IMG residents may be challenged in multiple ways–linguistically, socially, culturally–by the more patient-centered model they encounter in the U.S.

In addition, in a medical context miscommunication or inappropriate uses of linguistic resources can have adverse effects on interactions with patients.  If an IMG resident has not acquired or learned the necessary pragmalinguistic knowledge – vocabulary, language functions, a repertoire of lexical phrases – to be used appropriately during the medical encounter then their level of expertise as a medical practitioner can be interpreted as lacking professional qualifications due to these perceived linguistic shortcomings (Van de Poel & Brunfaut, 2010).  In

turn, it is possible IMG residents' pragmatic shortcomings may lead patients to misunderstand or misinterpret a range of medical encounter objectives, which could adversely affect patients' expectations and even treatment outcomes.

**Purpose of the Study**

Thus far in this introduction I have briefly discussed medical discourse socialization paying specific attention to the discourse activity of the medical encounter and its six phases. In light of the problems just explored in the previous section, I have illustrated how socialization into the medical discourse in a U.S. context poses potential pragmalinguistic challenges for IMG residents. In addition, I have discussed how physician and patient roles vis-à-vis issues of power and authority have been addressed in the literature and how these issues get enacted through interactions. Therefore, at this point and in light of what has been discussed thus far I wish to explicate the context and purpose of the study. The phase of the medical encounter that will receive primary study is the treatment advice phase. Specifically, the focus is on the interactions that take place between IMG residents and patients during the treatment advice phase. While some research has been conducted on this phase of the medical encounter (See section "Empirical studies focused on the treatment advice phase of the medical encounter" in Chapter Two for a review), to date none of the research has focused on IMG residents' interactions with patients during this treatment advice phase.

As regard the discourse that takes place in the treatment advice phase, I hypothesize IMG residents will be required to display more pragmatic competence in this phase as compared to other phases. This study aligns with previous research that has taken a co-constructive approach showing that physician-patient interactions of the treatment advice phase are characterized as a negotiated activity (Heritage & Clayman, 2010; Stivers 2005a, 2005b, 2006, 2007). Specifically,

patients and physicians ultimately negotiate by coming to some form of agreement regarding

patients' treatment plans. Consequently, taking a patient's viewpoint and opinions into

consideration requires that the IMG resident display a linguistic adeptness that entails a

knowledge of sociocultural norms and an ability to use them while maintaining positive patient

relations. In other words, the negotiation of a treatment plan entails more than simply

disseminating treatment advice and information; rather the negotiated treatment activity requires

that IMG residents draw on multiple resources–clinical, linguistic, and interpersonal – to attend

to the dual objectives of offering treatment and orienting to the relational side of interactions

with patients. To summarize, the aim of this study is to examine the co-constructed nature of the

treatment advice phase of the medical encounter and the ways in which IMG residents' treatment

directive strategies[4] and patient responses are managed and negotiated throughout the interaction.

**Research Questions**

The main research questions that guide this study are:

1. During interactions with patients, what are the organizational and structural features of

   the treatment advice phase of medical encounters?

2. In the treatment advice phase, what directive strategies do IMG residents use?

3. What is the relationship between the nature of the directives and patients' responses,

   including expressed likelihood of following the IMG residents' treatment advice?

4. In what ways is relational work used to manage (im)politeness in IMG resident-patient

   interactions?

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[4] A directive is a type of speech act that can be verbalized using various linguistic strategies (Ervin-Tripp, 1976). As will be fully explored in chapter two, the giving of (treatment) advice typically occurs through the issuance of a directive.

**Significance of the Study**

According to the Education Commission for Foreign Medical Graduates (ECFMG), in 2010 the number of IMGs currently practicing medicine in residency programs in the U.S. is approximately 25% of the entire resident population (Educational Commission of Foreign Medical Graduates Annual Report, 2010). This percentage is significant and growing; consequently it can be said that this is not an incidental and inconsequential population. Moreover, while some research has been conducted on the IMG population (See section "Empirical studies focused on international medical graduates' communication and language skills" in Chapter Two), additional research, especially related to communication and language use, needs to be conducted. One of the significant contributions of this study is that it will provide a detailed analysis into how IMG residents, especially those who are non-native English speakers, utilize their L2 within an institutional setting.

Additionally, this study aims to make an empirical contribution to the domain of medical discourse focused on the medical encounter. Specifically, this study aims to contribute to the physician-patient interaction literature in several essential ways. Though in general this body of literature is vast, scant research has been conducted on the resident population. Therefore, this study will fill a needed gap in the physician-patient interaction literature by examining this understudied population by specifically focusing on IMG residents. Hakulinen (2009) stated in a paper about different conversation types that "consultations and advice giving is a genre that is growing in importance in many different kinds of work place" (p. 63). Therefore, following this implicit call to conduct research on the giving of advice, this study will add additional empirical evidence into how the treatment advice phase of the medical encounter gets enacted. Additionally, the majority of the extant literature on the treatment advice phase occurs between

multiple parties, (i.e., physician, child patient, and parent) and focuses on the delivery of antibiotics as a possible treatment recommendation (Stivers 2005a, 2005b, 2006). This study will provide an additional contribution by examining a different type of interaction; that is, this study will focus on interactions with adult patients and where treatment advice is likely to involve a broader range of recommended courses of action.

This study will contribute to research on intercultural pragmatics and research on interlanguage pragmatics focused on language use. This study aims to demonstrate how interactions get played out pragmatically in one type of communicative activity, the medical encounter. As a study about language use, specifically IMG residents' use of directives to give advice, the study will contribute empirical evidence into how this speech activity gets enacted. Moreover, using a theoretical framework that focuses on how politeness is discursively constructed, this study may contribute empirical evidence to suggest an alternative to the dichotomous polite-impolite, rude-respectful portrayals of L2 English users.

Finally, the results of the study are likely to have pedagogical implications as well. Hoejke (2007) argues that IMG have "specific additional learning needs" as they go about becoming socialized into their local medical discourse community that can be addressed by dedicated English for Specific Purposes courses (p. 328). A review of the literature reveals that much is unknown about how IMG residents go about becoming linguistically and pragmatically proficient in their interactions with patients specifically and in the U.S. medical context in general. Consequently, due to the fact this study focuses on what IMG residents actually do with the English language it can provide valuable input into determining where potential needs, either linguistic, interpersonal, or related to socialization, can be addressed. In this way, this study provides a pedagogical contribution by demonstrating where IMG residents' pragmatic

competence could be addressed with additional focused education.   Furthermore, based on this study's findings a curriculum could be developed for IMG residents at the study's site to address their sociopragmatic and linguistic needs.

**Definitions of Terms**

Directives–Directives are a category of speech acts. Directives are defined as "attempts of varying degrees…by the speaker to get the hearer to do something" (Searle, 1976, p. 11).

International medical graduate (IMG)–The term international medical graduate (IMG) can broadly refer to all physicians who graduated from a medical school located outside the United States or Canada (Hoekje, 2011, p. 10).  Included in this broad categorization is both U.S. citizens and citizens from other countries. For purposes of this study, the term international medical graduate will refer to those physicians who attended medical school outside the United States.  Furthermore, when I refer to an international medical graduate who is participating in graduate medical education or residency education I will use the term IMG resident.  Moreover, when I refer to international medical graduates in a general sense I will use the terminology IMGs and in instances in which I reference a physician who has completed residency or the status is unclear or unstated then I will use the term IMG physician.

Program director–According to the ACGME, a program director is the "one physician designated with authority and accountability for the operation of the residency/fellowship program" (ACGME Glossary of Terms, 2013).  In other words, the program director is the primary leader of the residency program to whom all others turn for guidance, direction, and oversight.

Standardized patient–According to the Association of Standardized Patient Educators (ASPE), standardized patients are "individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies

based only on learner performance).  Standardized patients can be used for teaching and

assessment of learners including but not limited to history/consultation, physical examination

and other clinical skills in simulated clinical environments.  They can also be used to give

feedback and evaluate student performance" (ASPE Terminology Standards, n.d.).  Standardized

patients participate in role play, which is an instructional method used frequently in the U.S. in

both medical school and residency to simulate physician-patient interactions.

**CHAPTER TWO:  THEORETICAL FRAMEWORK AND LITERATURE REVIEW**

**Theoretical Framework:  Pragmatic competence as operationalized through institutional discourse, activity type, and relational work**

### Pragmatic competence.

The notion of communicative competence, arising from Hymes' (1972) reaction to Chomsky's restricted notion of linguistic competence, consists of interplay between grammatical competence and the knowledge of the sociocultural rules of appropriate language use.  Hymes' communicative competence approach was later extended or decomposed to include: grammatical competence, sociolinguistic competence, discourse competence, and strategic competence (Canale, 1983; Canale & Swain 1980).  The notion of pragmatic competence came into its own in Bachman's (1990) model of communicative language ability.  According to Bachman (1990), pragmatic competence consists of illocutionary competence and sociolinguistic competence. Illocutionary competence concerns knowledge about language functions and actions and sociolinguistic competence entails contextually appropriate uses of language functions. Therefore, as Bachman's notion of pragmatic competence makes clear, "pragmatic competence is not extra or ornamental" (Kasper, 1997, p. 2).  Rather, pragmatic abilities in the L2 are a part of a non-native speakers' communicative competence; consequently, it is necessary to locate pragmatic competence in a model of communicative ability.

Similar to Bachman's distinction between illocutionary and sociolinguistic competence, Leech's (1983) and Thomas' (1983) notions of pragmalinguistics and sociopragmatics can be

viewed in parallel ways. Furthermore, these two distinctive terms, pragmalinguistics and

sociopragmatics, provide useful descriptions about what pragmatic competence entails.

Pragmalinguistic knowledge concerns selecting the right language function or correct linguistic

form to convey a particular illocutionary force. Some language resources entailing

pragmalinguistic knowledge are pragmatic strategies, such as directness or indirectness, routines,

or a range of linguistic forms that can intensify or soften the force of a communicative act

(Kasper, 1997, p. 1). On the other hand, pragmalinguistic failure would result in the speaker

choosing the wrong linguistic resource to convey a particular intention. Sociopragmatic

knowledge is concerned with selecting a particular linguistic form and using it in an appropriate

sociocultural context; failure of this sort concerns using the language form in an inappropriate

context. Taken together then, Thomas (1983) tells us that "pragmalinguistic failure is basically a

linguistic problem, caused by differences in the linguistic encoding of pragmatic force,

sociopragmatic failure stems from cross-culturally different perceptions of what constitutes

appropriate linguistic behavior" (p. 99). These notions of pragmalinguistics and sociopragmatics

and the distinctions between them are important as regard understanding language in social use.

Furthermore, they provide a sound basis for formulating an understanding of pragmatic

competence. In essence, the communicative act, whether in a native or non-native language,

may be viewed as an attempt to utilize both pragmalinguistic and sociopragmatic knowledge.

Consequently, as regard L2 users it can be said that through the acquisition and utilization of

both these domains– pragmalinguistic and sociopragmatic knowledge–pragmatic competence

can be developed.

     The notion of pragmatic competence has been operationalized in various ways in second

and foreign language studies (See Bardovi-Harlig, 2010 for a comprehensive review). In this

study pragmatic competence is conceptualized through multiple theoretical frameworks. In other words, I operationalize the notion of pragmatic competence by taking a multi-layered approach. Specifically, pragmatic competence will be examined through three different layers: (a) within the institution, (b) at the activity level, and (c) through (im)polite interaction. As discussed in the introduction, in order to demonstrate competency on multiple levels it is necessary for IMG residents to function within the medical institution by using various discourses of medicine. One such discourse activity type IMG residents must become competent in is the medical encounter. Within this activity IMG residents must appropriate pragmalinguistic and sociopragmatic knowledge and use this knowledge to carry out this culturally-specific activity. Moreover, to maintain positive relations with patients during medical encounter interactions, IMG residents (and patients) utilize linguistic strategies that may be perceived as polite or impolite and which may consequentially affect treatment outcomes.

In the section that follows I will discuss further the three layers underpinning pragmatic competence in this study. Specifically, I will provide a brief overview of institutional discourse and discuss the specific framework guiding this study. Next, I will introduce Levinson's (1992) notion of activity type and discuss how the medical encounter is a cultural-specific activity. Finally, as a theoretical lens into the interactional work that gets done between IMG resident and patient, I will discuss theories of (im)politeness and relational work.

**Institutional discourse.**

Over the years several models or principles about what constitutes institutional discourse have been proposed (Agar, 1985; Drew & Heritage, 1992). In so doing, these scholars make attempts to characterize or point to some features that distinguish institutional discourse (also commonly referred to as institutional talk) from casual, everyday conversation. For instance,

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Agar (1985) postulated that institutional discourse must accomplish three things: (a) *diagnose* the nature of a client's problem, (b) *direct* the client to perform some future action, and (c) *report* the results of the interaction. In another institutional discourse framework, the model used to ground this study, Drew and Heritage (1992) proposed three tenets about institutional talk;

- it is goal-oriented in institutionally relevant ways;

- it may involve special and particular constraints on contributions; and

- it may be associated with inferential frameworks and procedures (p. 22).

Unlike ordinary conversation, institutional-based conversation typically orients to a particular purpose or task with a goal or outcome as the end result. Task orientation is manifest in the discourse of the medical encounter, characterized by its question-answer format where questions have a clear institutional purpose. Moreover, a main goal of the medical encounter is to review the patient and diagnose a presenting medical problem. Following Levinson's (1992) discussion of constraints apropos his notion of "activity types" (See "Levinson's (1992) activity type" section below), Drew and Heritage (1992) also postulate that interactants' contributions while participating in institutional discourse are constrained in many ways. Thus, in addition to serving to structure the medical encounter, the question-answer sequence also functions as a constraint on discourse. For example, this structure limits patients' ability to adequately respond. Finally, institutional discourse is characterized by unique inferential features. For example, the expression of surprise or agreement by a professional, such as a physician, is often considered inappropriate in institutional talk, which is not the case in casual conversation. Such withholdings might be considered antagonistic in ordinary conversation but in institutional discourse such inferences are not so readily taken up (Drew & Heritage, 1992, p. 24). In summary, then, these three distinguishing factors–goal orientation, restrictions on contribution to

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talk, and distinctive interactional inference features–provide an institutional flavor to talk in the name of work.

Institutional discourse provides the overarching framework for this study. It can be said that all forms of medical discourse from the frontstage to the backstage, metaphorically alluded to in the introduction, contain the defining features discussed in this section. In this way, it becomes clear that the medical encounter, the discourse under examination in this study, can be treated as a goal-oriented, constrained activity with unique inferencing characteristics. Consequently, institutional discourse provides a meaningful framework through which to view a variety of discourse features, such as activities and interaction. With this in mind, it is to one such discourse feature, the activity type, that I now turn.

**Levinson's (1992) activity type.**

Expanding on Wittgenstein's (1958) implicit assumption made in his "language games" doctrine "to embed language within human activities," Levinson proposed a meaning in context framework through his conceptualization of *activity types* (Levinson, 1992, p. 67). Levinson (1992) defines activity type as "a fuzzy category whose focal members are goal-defined, socially constituted, bounded, events with *constraints* on participants, setting, and so on, but above all on the kinds of allowable contributions" (p. 69, emphasis in the original). In this notion of activity types Levinson makes two primary points: (a) constraints on allowable contributions, and (b) inferential schemata (p. 71-72). As regard the first point regarding constraints, Levinson is interested in explicating the ways in which the "structural properties of an activity constrain the verbal contributions that can be made toward it" (p. 71). Also attributable to structural properties of the activity are the inferences interlocutors are able to derive from the activity in question. Levinson argues that background knowledge and expectations about a particular activity type are

necessary in order for interlocutors to make meaningful inferences during interactions. In addition to expectations governing activity, inferencing also relies on functional constraints that utterances are bound to have within a given activity type.

It is possible then, as Levinson does in his paper, to view the medical encounter as an activity type. As briefly outlined in the introduction, it is clear to see how the medical encounter and its various phases can be characterized as an activity type. Here, a few defining features will be used to demonstrate this point. First, the medical encounter is organized as an activity toward a diagnostic goal. In addition, the structure of the phases (Levinson terms phases of an activity "episodes") is predominated by a question-answer sequence with the physician asking questions and the patient providing responses. For instance, the physician's opening question *How are you?* more often then not constrains the patients response to talk of a clinical nature. The same constraint would not be imposed if the opening question *How are you?* were delivered in different activity type, such as a social gathering. In this way, we can see how the function of talk, such as the question *How are you?,* "derives its meaning from the activity type in which it is embedded" (Sarangi, 2000, p. 2). Moreover, the medical encounter is constituted through the social interaction between participants, but the participants are constrained by the roles they assume as physician and patient.

Levinson (1992) closes his paper by making the point that knowing the "language rules of the game" of different activity types has cross-cultural communication implications. In regard to knowing the constraints on allowable contributions, Levinson (1992) states this is an important part of communicative competence and one's ability to draw on knowledge of the sociocultural rules of appropriate language use. Secondly, as regard the "activity-specific rules of inference", Levinson (1992) again notes the importance of communicative competence by

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being able to understand what one hears.  He continues, "And because these activity-specific

rules of inference are more culturally specific than other sorts, they are likely to play a large role

in cross-cultural or interethnic communication" (p. 97).  Consequently, significant connections

can be made between this idea that different activity types have cross-cultural implications and

the population under examination in this study.  That is, in order for IMG residents to be

communicatively (and pragmatically) competent during the medical encounter, it will be

necessary for them to learn and function within the medical encounter's linguistic and

sociocultural rules.  In this way, IMG residents participate in a process of "double-socialization":

they are socialized into the norms of the L2 discourse community and the norms of the U.S.

medical discourse community.  The implications are that IMG residents who know the rules of

the game are likely to be perceived by others as communicatively competent as compared to

those who have not or chose not to learn the rules of the game.

In short, Levinson makes clear how activity types are specific to different cultures.  As

such, socialization into the cultural specific rules of different activity types, such as the medical

encounter, occurs over time.  Thus, like the different institutional discourses IMG residents must

learn they too must be socialized into the ways of doing the medical encounter activity type.

Finally, though it is not the principle thrust of his paper, Levinson (1992) demonstrates how he

considers activity types to be an essentially pragmatic notion.  Thus, it is to the pragmatic nature

of talk that I now turn as I give attention to the third layer of the theoretical framework.

**(Im)politeness and relational work.**

As Haugh (2010) tells us, there is no specific theory on intercultural politeness.  (p. 140).

Consequently, over the years, researchers working in the areas of cross-cultural and

interlanguage pragmatics have grounded much of their empirical work in politeness theories

appropriated from the field of pragmatics (Kasper & Rose, 2002). Two main theories of (im)politeness will be presented in this section to compare and contrast the different approaches. The two approaches presented are: Brown and Levinson's (1987) theory of politeness and Watt's and Locher's notion of relational work (Locher, 2006; Locher & Watts, 2005; Watts, 2003). This latter approach to (im)politeness, Watt's and Locher's notion of relational work, will be used to underpin this study.

Many scholars (e.g., Brown & Levinson, 1987; Fraser, 1990; Scollon, Scollon, & Jones, 2012; Watts, 2003) have appropriated Goffman's notion of face and facework to ground their theory of politeness. As Scollon et al. (2012) point out, any communicative act is a "risk to face" (p. 48). Goffman (1961) defined face as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (p. 5). Thus, face may be perceived as a personal attribute or possession but the central idea of the definition lies with the social or outward view of face. In other words, the notion of face is enacted and attended to when interlocutors are engaged in social actions. Through what Goffman (1961) terms "the rules of self-respect and the rules of considerateness" (p. 11), in interactions individuals are expected to adhere to certain social rules so as to maintain both their own face as well as the face of other interlocutors. Consequently, any social interaction can be characterized by an attempt to achieve balance between a defensive posture of saving one's own face and a protective posture of saving the other's face (p. 14). Further, Goffman states that this kind of "mutual 'face' acceptance seems to be the basic structural feature of interaction" (p. 11).

In light of this notion of face, Brown and Levinson (1987) proposed two facets of face interlocutors can enact when engaged in interaction. Positive face "is the positive consistent self-image or 'personality' claimed by interactants" (Brown & Levinson, 1987, p. 61). On the

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other hand, negative face is "the basic claim to freedom of action and freedom from imposition" (Brown & Levinson, 1987, p. 61). Thus, according to Brown and Levinson (1987), interlocutors use politeness strategies to attend to both positive and negative faces. Importantly, both face needs of the speaker and the hearer, in other words to both the self and other, are attended to by using politeness strategies.

However, there are times in everyday interactions that an interlocutor's face needs and wants are not attended to or are threatened by others. Brown and Levinson (1987) call these episodes "face threatening acts" (FTAs) (p. 60), which are a central tenet of their politeness theory. In this way, Brown and Levinson (1987) view politeness as a complex system for softening the "blow" of FTAs. Particular speech acts are said to be more threatening to face needs than others. For instance, certain directives, such as orders and requests, are said to mainly threatening an addressee's negative face wants because directives impede addressees' basic claims to freedom of action and freedom of imposition. Moreover, other speech acts, such as apologizing and expressing thanks, are said to impede speakers' face wants. Accordingly, Brown and Levinson (1987) devised five strategies for performing FTAs of which two shall be briefly discussed here.

Brown and Levinson (1987) use the term "redress" to refer to actions interlocutors take to "give face" to the addressee by modifying the utterance in such a way so as to clearly indicate no FTA is intended or desired (p. 69-70). Redressive actions are used in two of their strategies: positive politeness and negative politeness. Employing positive politeness strategies to soften the "blow" of an FTA entail attending to the positive face needs of the addressee. In an effort to describe different positive politeness strategies, Scollon et al. (2012) use the term involvement strategies to describe the ways interlocutors can orient to the addressee's positive face.

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Involvement strategies entail, for example, claiming a common point of view, claiming in-group membership, or simply being optimistic. As well, Brown and Levinson (1987) list 15 different positive politeness strategies interlocutors can use to avoid threatening an addressee's positive face. On the other hand, negative politeness strategies attend to the negative face needs of the addressee. To address negative politeness, Scollon et al. (2012) employ the term independence strategies. Some independence strategies to attend to negative face are: make minimal assumptions, minimize threat, apologize, and give the option not to act (Scollon et al. 2012, p. 50-51). In the same manner, Brown and Levinson (1987) list 10 different negative politeness strategies interlocutors can use to avoid threatening an addressee's negative face.

Brown and Levinson's theory of politeness has served as a cornerstone of research underpinning many pragmatic empirical studies on both native and second/foreign language speakers. That said, it is also a theory that has received a number of challenges. For instance, the theory is frequently criticized for claiming to be too universal (after all, the term "universal" is a part of the title) and does not pay particular attention to cross-cultural differences in the ways in which politeness is expressed and attended to in different languages and cultures (See Ide, 1989; Matsumoto, 1988, 1989 for a Japanese perspective and Gu, 1990 for a Chinese viewpoint). Moreover, other (im)politeness scholars claim that "no utterance is inherently polite" (Locher, 2006, p. 251; Locher & Watts, 2005, p. 16) and consequently argue that Brown and Levinson's politeness theory is really more an exercise in the mitigation of FTAs (Locher & Watts, 2005).

As a consequence, in recent years some scholars have been working towards refining Brown and Levinson's seminal politeness theory. One such reconceptualization proposes the notion of relational work, as put forth by Richard Watts and Miriam Locher (Locher, 2006; Locher & Watts, 2005; Watts, 2003), as an alternative view of politeness. In this approach,

relational work is viewed as a discursive act between interactants and is the "'work' individuals invest in negotiating relationships with others" (Locher & Watts, 2005, p. 9).

Similar to Brown and Levinson (1987) and Scollon et al. (2012), relational work is also grounded in the notion of face and facework. As a part of relational work, the notion of face as an inherently social attribute is a central tenant, as Goffman (1967) stated, "While his social face can be his most personal possession…it is only on loan to him from society" (p. 10). Consequently, through relational work one's face is negotiated and constructed continually in and over the course of social interactions.

Taking this notion one step further, as stated previously "no utterance is inherently polite" (Locher, 2006, p. 251; Locher & Watts, 2005, p. 16). Thus, taking a discursive approach to politeness is in slight opposition to Brown and Levinson's (1987) approach, which tends to take a speaker-only view by focusing on the linguistic acts the speaker can enact to mitigate threats or save the addressee's face. In comparison, the discursive approach to relational work pays equal attention to both the speaker and hearer in interaction. As a consequence of Brown and Levinson's (1987) focus on FTAs and concomitant strategies to mitigate them, politeness theory only makes a distinction between politeness and impoliteness. It is argued that through relational work it is possible to consider behavior in an interaction as merely appropriate[5], and neither polite nor impolite. Consequently, "relational work comprises the entire continuum of verbal behavior from direct, impolite, rude, or aggressive interaction through to polite interaction, encompassing both appropriate and inappropriate forms of social behavior" (Locher & Watts, 2005, p. 11).

However, the question becomes: how do interactants decide how to classify verbal behavior? In other words, how is it that an interaction is deemed polite, impolite or merely

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[5] Watts (2003) also calls unmarked, socially appropriate behavior "politic behavior" (p. 20).

appropriate? To help answer this question, following Eelen (2001), Watts (2003) makes a distinction between politeness$_1$ and politeness$_2$. Politeness$_1$, also called first-order politeness, refers to the "folk or "lay" interpretations individuals make about whether an interaction was polite or not. Importantly, the interpretations that form first-order politeness determinations are formed through previous interactional experiences, and are shaped by the social norms and practices associated with everyday conversations, institutions, and society. In other words, as social, interacting human beings, we are socialized into making first-order politeness interpretations. In comparison, politeness$_2$, or second-order politeness, refers to the sociolinguistic constructs or theories proposed about politeness (Watts, 2003, p. 4). In this way, politeness$_2$ interpretations are conceived using the analyst's categories and follow an interpretative, top-down approach. Importantly then, as a discursive approach to (im)politeness, "rather than imposing second-order politeness principles in retrospect on linguistic data, it is important to recognize that terms such as 'impolite', 'polite' or 'appropriate' are inherently evaluative and normative" and are shaped by politeness$_1$ interpretations (Locher, 2006, p. 252). Consequently, the discursive approach to politeness leaves open the possibility of different interpretations and perceptions.

Locher (2006) provided an empirical example of relational work in naturally occurring data. Using data from an internet-based advice-giving column on health issues, Locher (2006) examined the questions and responses through both a Brown and Levinsonian interpretation of data and through a discursive approach to politeness. In the column, advice was given in the form of declaratives, imperatives, and interrogatives. Locher (2006) argued that the use of mitigation strategies was not an automatic claim to politeness and the use of imperatives was not necessarily less polite than the mitigated forms (p. 262). Rather Locher (2006) argued that if

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both a mixture of direct and indirect strategies were used then they comprised "different displays of relational work that together form the particular norm of the appropriate and non-polite way of advice-giving established over time in this particular communicative framework by interactants" (p. 262). Moreover, Locher (2006) explained that advice-seekers unfamiliar with the discursive norms of the column may have different reactions to it based on "their previous acculturation to norms of advice-giving established in other contexts" (p. 263).

The notion of politeness as norm-dependent and evaluative may provide some analytical challenges when examining casual conversation. However, in this study, one activity type, the medical encounter, is under examination. Consequently, by examining one structured activity type, the evaluations of (im)politeness are limited to this one type of interaction, thus facilitating the interpretative work. In addition, Locher (2006) and the notion of relational work in general have important and necessary implications related to L2 pragmatics studies. It is necessary to consider that using the traditional dichotomous approach of politeness and impoliteness, L2 users have sometimes been empirically characterized as impolite based on their linguistic choices (e.g., directness, lack of hedging). However, the study of relational work demonstrates that politeness is a fluid concept, comes in many shades, is locally negotiated through interaction, and interpretations are shaped by participants' background knowledge. As such, the notion of relational work presents an alternative approach for examining the strategies L2 users utilize to engage in (im)polite interactions.

Finally, to conclude this section it is necessary to briefly discuss the different social and contextual factors that influence the use of (im)politeness strategies. All (im)politeness theories, including the theories discussed above, consider these factors as a part of their theory (Kasper, 2009). The three main factors that politeness theorists have evaluated to determine their role in

the enactment of (im)politeness are:  power, (social) distance, and weight of the imposition (imposition only occurs with individual speech acts).  These factors come into play every time we engage in communicative activity and oftentimes different linguistic strategies are employed to maintain positive interpersonal relations.

## Literature Review

To inform my understanding about how IMG residents may perform interactions with patients during medical encounters, it is necessary to examine various areas of literature from several vantage points.  To inform this study with pertinent theoretical and empirical research, I focus on three distinct areas. I focus on the theoretical and empirical research related to the speech act of directives.  This area of research is pertinent due to the fact that the different ways IMG residents may present treatment recommendations or advice are considered a type of directive speech act.  In this section of the literature review, I also present the few studies that have examined the speech act of advice giving. In addition, research studies that have previously examined the treatment advice phase of the medical encounter will be examined.  Finally, findings from studies that have taken a qualitative or discourse approach to examining IMG residents, as a distinct group of physicians in the medical context, are also presented in the literature review.

### Directives.

*Theoretical considerations.*

This section of the literature review focuses on the particular speech act of directives. Due to the fact research question two specifically focuses on the directives speech act, this study is situated in this research domain.  Consequently previous research conducted on directives informs the study as regard methodology, guiding questions, and findings (Holmes & Stubbe,

2003; Vine, 2004; West, 1990; Yates, 2005). The section demonstrates how concepts such as

social distance, power, face, and politeness get enacted through the directive speech act. The

section is divided into two main sections. It will begin with a brief overview of the various

theoretical conceptualizations of directives that have been put forth over the years. Following

this overview, I will present the literature exploring the varying questions researchers have

attempted to answer as regard directives.

Searle (1976) provides a succinct and oft-quoted definition of directives. That is,

directives are "attempts of varying degrees…by the speaker to get the hearer to do something"

(p. 11). However, as the following section reveals, how researchers conceptualize and employ

this definition of directives in their own work varies. This ambiguity emanates, in part, from a

long and contested history in which various linguists and language philosophers have attempted

to define and refine preexisting classifications of speech acts in general and the directive speech

act specifically (Austin, 1962; Bach & Harnish, 1979; Ervin-Tripp, 1976; Searle, 1976; Tsui,

1994).

Austin (1962) put forth the first taxonomy and used five categories to classify different

types of speech acts – *verdictives*, *exercitives*, *commissives*, *expositives*, and *behabitives*. The

category *exercitives* is most closely associated with what recent literature categorizes as

directives. Finding flaws with Austin's model, mainly for its lack of a principled classification

system, Searle (1976) devised the next taxonomy. His taxonomy was the only one tied to the

general theory of illocutionary acts (Bach & Harnish, 1979). In his model Searle used five

categories–*representatives* (or *assertives*), *directives*, *commissives*, *expressives*, and

*declarations*–to define illocutionary acts. As previously mentioned, Searle (1976) defined

directives as "attempts of varying degrees…by the speaker to get the hearer to do something" (p.

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11). Verbs associated with directives are *ask*, *order*, *command*, *request*, *beg*, *plead*, *pray*, *entreat*, and also *invite*, *permit*, and *advise* (Searle, 1976, p. 11). In addition to defining each category, Searle also provided the basic syntactic structure for each of them.

Bringing into focus "illocutionary intents or expressed attitudes" (p. 40) Bach and Harnish (1979) proposed an additional taxonomy. Their taxonomy is divided into four main communicative illocutionary acts: *constatives*, *directives*, *commissives*, and *acknowledgments*. Finding Austin's *exercitive* term too restrictive for their *directive* category, they borrowed Searle's terminology. They go on to say, the term *directive* is "both to the point and conveniently vague" (p. 47). According to Bach and Harnish, *directives* "express the speaker's attitude toward some prospective action by the hearer and his intention that his utterance, or the attitude it expresses, be taken as a reason for the hearer's action" (p. 41).

Unlike Austin and Searle before them, Bach and Harnish (1979) helpfully provide sub-categories under each main category. For directives, the sub-categories they offer to further subdivide and define this main category are *requestives*, *questions*, *requirements*, *prohibitives*, *permissives*, and *advisories*. In their discussion of each of these sub-categories Bach and Harnish provide evidence of speaker intention and through these sub-categories it becomes clear how each type of directive operates differently. This distinction is clearly seen through the comparison between *requestives* and *requirements* (a common type of *requirement* is an order). *Requestives* express "the speaker's desire that the hearer do something" (p. 48). In *requirements*, the speaker's intention is that the utterance itself serves as a reason for the hearer to do something (p. 48). In other words, with *requirements* the speaker's desire as to whether the hearer actually performs the act is inconsequential. Rather *requirements* express the speaker's belief that the utterance itself constitutes sufficient reason for the hearer to act. Thus, the

primary difference expressed between these two different types of directives, *requestives* versus *requirements*, relates to the speaker's position of authority over the hearer.  In Bach and Harnish's taxonomy, a *directive* is termed a *requirement* if the speaker has authority over the hearer.  Moreover, a *directive* is categorized as a *requestive* if the speaker does not have authority over the hearer.  Consequently, this defining characteristic of authority used to differentiate between *requirements* and *requestives* can provide useful information to aid in determining the type of directive being used in spoken interaction.

Expanding the discussion of *directives*, Tsui (1994) takes a different position as regard the arguments presented thus far.  She argues that *directives* and *requestives*, which are types of "discourse acts" (p. 52), fall into two distinct categories.  While she agrees that *requirements* or *orders* entail the speaker having authority over the hearer and requests do not suggest such authority, she states "these are not the crucial differences" (p. 92).  Rather, Tsui takes a perlocutionary, or hearer perspective, and argues that the issue of compliance or non-compliance on the part of the hearer adds to the crucial and distinctive differences between the two categories.  That is, in a request the hearer has a right to withhold compliance and not perform the action.  Furthermore, the speaker is obligated to acknowledge the hearer's right.  Conversely, in an order (or *directive* using Tsui's term), the hearer is expected to cooperate and is not afforded the right of non-compliance.  Later in her discussion, Tsui acknowledges the shared roles authority and compliance play on speaker and hearer intentionality.  It is clear that if a speaker has authority over a hearer the likelihood of compliance on the hearer's part is high.  In contrast, when the speaker has no authoritative rights over the hearer, the hearer's willingness to comply remains open for debate.  In her acknowledgement of hearers' rights and intentions, Tsui

broadens the speech action discussion to consider both sides of the conversation – that of the speaker and the hearer.

Additionally, Tsui (1994) reconsiders what have been termed thus far as *exercitives* by Austin, *directives* by Searle, and Bach and Harnish's sub-category of *requirements*. Tsui argues that this term should be further categorized resulting in two subclasses of directives: *advisives* and *mandatives*. In this case, who benefits from the action is at issue. If the hearer of the directive benefits from the action then Tsui terms this action an *advisive*. Two *advisive* verbs Tsui discusses are warn and advise. On the other hand, if the action benefits the speaker then Tsui regards this action as a *mandative*. Instructions and threats are examples of *mandatives*.

Upon further analysis, Tsui's *advisives* classification bears considerable resemblance to Bach and Harnish's sub-category of *advisories*. According to Bach and Harnish (1979), *advisories* are defined as "what the speaker expresses is not the desire that the hearer do a certain action but the belief that doing it is a good idea, that *it is in the hearer's interest*" (italics added) (p. 49). They also include the verbs *advise* and *warn* as types of *advisories*, in addition to *admonish*, *recommend*, *suggest*, and *urge*. Again, examining the hearer's perspective, *advisives* or *advisories* consider the benefits of the action being performed. Furthermore, Bach and Harnish also tell us that some advisories (e.g., warning) "imply a special reason" (p. 49) that the action recommended is a good idea.

The notion of an action benefiting the hearer or having the hearer's best interests in mind have important implications for this study. I hypothesize that during the treatment advice phase of a medical encounter, a physician advises the patient on the best course of action to heal, cure, or improve a health condition or outcome. To improve health can most certainly serve as an example of an "implied special reason" to which Bach and Harnish allude in their definition of

*advisories*. Consequently, their definition of advice has important significance in the analysis of IMG resident-patient interactions. I take the position that the majority of directives performed in the treatment phase of the examined medical encounters will fall into the *advisives* or *advisories* category. Consequently, I call attention to this sub-category of directives that has received minimal attention in the literature (See brief review of advice-giving literature below) to highlight its potential significance to this study.

Ervin-Tripp (1976) provided the most influential and empirically grounded treatment of directives in her proposal of a form-function taxonomy. Subsequent to its publication, several researchers (Pearson, 1989; Pufahl Bax, 1986; Weigel & Weigle, 1985) employed Ervin-Tripp's (1976) directives taxonomy to classify their directives data and in some instances made an effort to replicate findings. Thus, Ervin-Tripp's taxonomy will briefly be reviewed here before moving on to the empirical studies.

In contrast to the taxonomies presented thus far however, Ervin-Tripp (1976) focused exclusively on the *directives* speech act. Additionally, her study provided a detailed account of syntactic structures used to utter directives, the functions they serve, and the social and contextual variables that affect their formulation. Data collection procedures primarily included ethnographic methods and the audio-recording of naturally-occurring conversations. Interactions occurred in a variety of settings: family, office, hospital, service encounters, and classrooms. Ervin-Tripp's (1976) corpus revealed six different directive forms that ranged from explicit to highly indirect, which left open inferential interpretation. The six directive forms, which are "ordered approximately according to the relative power of speaker and addressee in conventional usage and the obviousness of the directive" (p. 29) are:

- *need statements* such as "I need a match";

- *imperatives* such as "gimme a match" or elliptical forms like "a match";

- *imbedded imperatives* such as "could you gimme a match?";

- *permission directives* like "May I have a match?";

- *question directives* such as "gotta match?"; and

- *hints* like "the matches are all gone" (p. 29).

In regard to social and contextual variables that influence the selection of the directive form used, the data in Ervin-Tripp's (1976) corpus revealed that rank, age, familiarity, presence of outsiders, territorial location, and role expectations were influential determinants (p. 36). In reference to the specific setting under investigation in this study, Ervin-Tripp (1976) noted that medical settings emphasized rank more than other occupational settings; higher-ranking individuals employed the imperative form when interacting with lower-ranking individuals. Importantly, the examples Ervin-Tripp used in the medical context to draw this interpretation were interactions between colleagues (e.g., between doctor and nurse). Therefore, given the fact the focus of this study is on physician-patient interactions, it remains to be seen whether the use of the imperative form will be found in this type of medical-related interaction.

### *Empirical studies focused on the use of directives in institutional settings.*

In this section I focus on empirical studies examining directives that directly relate to my study in three primary areas. Attention will be given to studies that have examined the notions of power and politeness in relation to directive usage due to the theoretical focus of this study. In addition, studies that have examined the particular directive of advice giving will receive focus. Finally, empirical studies that have examined directive usage in intercultural communication will also be fully explored. Clearly, other empirical studies also exist on use of directives in institutional settings; several of these studies are displayed in Table 1 in this section of the

literature review.  This table is used to provide the reader with a comprehensive and visual

overview of the directive studies conducted but not referred to in detail in this section of the

literature review.  The table highlights the studies' key components:  setting, participants,

methodology, findings, and additional notes for each study.

Studies examining directives in institutional settings have utilized a wide range of

contexts.  Many researchers have limited the examined interactions to a single setting or context.

Holmes (1983) and Yates (2005) investigated teachers' directives in classroom settings; Pufahl

Bax (1986), Reinhardt (2010), and Williams (2005) investigated directives in various university

settings; Weigel and Weigel (1985) examined directives in a migrant agricultural community;

Pearson (1989) examined church business meetings; West (1990) investigated physician-patient

interactions; Vine (2004, 2009) examined governmental workplaces; Perren (2008) examined

nonprofit organizations; and Halbe (2011) investigated military office situations.  Other

researchers, on the other hand, have employed a broad approach by including multiple and

different institutional settings in their study (Clyne, 1994; Ervin-Tripp, 1976; Holmes & Stubbe,

2003; Koester, 2002, 2006).

Similar to the variety of institutional settings used, research questions used to explore

directives have been equally diverse.  By far the most common approach taken in directive

research has been to explore the social factors determining power and the politeness strategies

used to aggravate or mitigate directives (e.g., Halbe, 2011; Holmes & Stubbe, 2003; Koester,

2006; Pearson, 1989; Pufahl Bax, 1986; Vine, 2004, 2009; Weigel & Weigel, 1985).  In short,

issues of power and politeness predominate in this area of research.  Focusing on different

contextual factors, other approaches researchers have undertaken have focused on gender

differences (Clyne, 1994; West, 1990), explored individual differences and styles (Reinhardt,

2010; Yates, 2005), investigated cultural variation (Clyne, 1994), compared learners to experts (Reinhardt, 2010), compared spoken to written directives (Pufahl Bax, 1986), examined responses to directives (Halbe, 2011; Heritage & Sefi, 1992; Leppänen, 1998), and explored the various discourse devices used in the interactions (Holmes & Stubbe, 2003; Pufahl Bax, 1986; Vine, 2004, 2009).

Directives have played a main or supporting role in several book-length treatments that have examined interactions in institutional settings (Clyne, 1994; Holmes & Stubbe, 2003; Koester, 2006; Vine 2004). Three of the books will be briefly reviewed in this section.

Holmes and Stubbe (2003) followed a social constructionist model of communication in their book *Power and Politeness in the Workplace: A Sociolinguistic Analysis of Talk at Work* and explored a broad range of different interaction types–small talk, interactions in meetings, the use of humor, and miscommunication. The corpus of spoken interactional data that formed the basis of the book and was used to illustrate examples was the Language in the Workplace Project[6]. A broad range of workplaces comprised the corpus; it included government departments, factories, small businesses, and public and private organizations.

Holmes and Stubbe (2003) dedicated chapter three to the analysis and discussion of interactions concerned with giving directions and making requests. In this chapter Holmes and Stubbe (2003) used numerous examples to illustrate how power and status influenced interactants' linguistic choices and politeness strategies while getting work done. For example, in relationships where there were no status differences, Holmes and Stubbe's (2003) analysis indicated that the role power played was diminished. They showed how interactants used

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[6] The Language in the Workplace Project is associated with Victoria University of Wellington in New Zealand. Started in 1996, the aim of the project is to identify the characteristics of effective communication between people, diagnose possible causes of miscommunication and explore possible applications of the findings for New Zealand workplaces. The project's website is: http://www.victoria.ac.nz/lals/lwp

indirect politeness strategies to manage the transactional and relational goals of the interactions. On the other hand, in hierarchical relationships, where a superior was directing a subordinate, Holmes and Stubbe (2003) demonstrated how superiors managed their use of power in conversations through a variety of intensifying (e.g., *very*, *definitely*, the use of repetition) and mitigating (e.g., the use of modal verbs, hedged syntactic structures, tag questions) pragmalinguistic devices.

In addition to power, Holmes and Stubbe's (2003) examples also demonstrated how "considerations of setting and context, the nature and length of their relationship with the person they are talking to, and the nature of the required task" (p. 40) were all relevant factors in determining the discourse strategies taken by superiors. "Getting the boss to cooperate" (p. 43), or interactions in which the subordinate was directing or requesting a superior to perform an action primarily benefitting the subordinate were characterized by indirect or deferential discourse strategies. Moreover, they stated these deferential politeness strategies increased as status differences increased (p. 46). In a situation such as this, a strategy a subordinate may employ is a hint, in which the need to act is inferred. Hints fall into Brown and Levinson's (1987) 'off record' category of face-threatening acts, considered the most indirect strategy, which Ervin-Tripp's (1976) taxonomy also revealed. Holmes and Stubbe (2003) examined some of the forms hints take in the workplace and, in addition to being employed by subordinates to superiors, hints were also used when the degree of social distance between interactants was great or when the weight of imposition was high (p. 52).

In *Getting Things Done at Work: The Discourse of Power in Workplace Interaction* Vine (2004) examined three specific control acts[7]–directives, requests, and advice–to explore the use

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[7] Ervin-Tripp, Guo, and Lampert (1990) used the term "control acts" in their paper examining the speech acts and persuasion tactics of children. Ervin-Tripp et al. define "control "acts' as "acts intended to control the behavior of

of power in a New Zealand workplace. The spoken interaction data came from four different

government workplaces and were also collected as part of the Language in the Workplace

Project. In this book Vine used a form-function approach to analyze the three different control

acts.

The study focused on four participants (all women) engaged in power-differential and

power-congruent spoken interactions. In power-differential interactions, where a hierarchical

difference between participants exists, the participants used a variety of explicit forms that were

always mitigated (e.g., the use of internal modification such the use of past tense, the inclusive

pronoun *we*, and the use of "grounders" to externally modify the control act) in some way (p.

165). In addition to these mitigation strategies, those in more powerful positions employed other

discourse strategies, such as asking not telling how to do something or involving others in

decision-making to minimize status differences (p. 199). Similar to Holmes and Stubbe (2003),

Vine also explored the use of control acts and the enactment of power in interactions among

equals; in other words where there is no status difference among the participants. Similar to

power-differential interactions, the control acts in power-congruent interactions took a variety of

forms that were always internally and externally mitigated (p. 217). Moreover, collaborative

discourse strategies were used, such as the acknowledgment of expertise power and the

recognition of face needs as a way to build solidarity between interlocutors.

The strength of these book-length examinations rests with their use of relatively large sets

of data. Vine (2004) analyzed 52 different interactions, and according to Holmes and Stubbe

(2003), the Language in the Workplace Project corpus consisted of approximately 2,000 spoken

others" (p. 307) or "acts intended to produce change in the actions of others" (p. 308). According to Ervin-Tripp et al., "control acts" are comprised of a family of acts, such as *directives*, *prohibitions*, *invitations*, *offers*, *claims*, *intention statements*, and *permissions* (p. 308). Some researchers have taken up this "control acts" terminology and have used it in their research to examine specific acts (e.g., Pearson, 1989, for *directives* and *disagreements*; Vine, 2004, for *directives*, *requests*, and *advice*).

interactions. By comparison, other studies, such as those reviewed below (See Clyne, 1994 and

Reinhardt, 2010 for exceptions) and as found in Table 1, consist of much smaller data sets. In

addition to quantity, the quality of these corpora is characterized by a wide variety of workplace

settings, from governmental departments to small business settings. Additionally, different types

of interactions, such as one-on-one meetings, and formal and informal talk, were collected and

analyzed. Taken together, these book-length investigations of workplace discourse, specifically

the workplace discourse of directing, reveal interactional complexities and the multiple social

and contextual factors that influence interactions among equals and where status differences

exist.

In addition to examining symmetrical-asymmetrical workplace relationships as

demonstrated by these two studies, other studies focused on directive use have found additional

social and contextual factors that have influenced the power dynamics and politeness strategies

used in the interactions. For instance, in a medical clinic setting West (1990) examined the ways

in which gender influenced directive usage in resident physician-patient interactions. She found

that male residents used aggravated directive forms 81% of the time. In comparison, female

residents used mitigated forms of directives, which West called "proposals for joint action" (p.

98) instead of directives. Weigel and Weigel (1985) found that the social class and ethnic

composition of their participants, black male migratory agricultural laborers, as well as the

unstable, unbalanced hierarchical structure that defined their work community, influenced

directive usage with the imperative form used almost exclusively. In a very specific institutional

setting, military office situations, Halbe (2011) provided insights into how the rules of politeness

were enacted in various speech events. Overall, Halbe (2011) found that the linguistic strategies

used were by "no means as rigid or formal as expected" (p. 332). However, while politeness was

quite pervasive, in the end, the data revealed power and social distance overruled considerations of politeness (p. 333).  Consequently, as these studies have shown, gender, ethnicity, and the institutional setting itself may be variables that play a role the IMG resident-patient interactions under examination in this proposed study.

*Intercultural communication studies.*

As this study will focus on intercultural communication, it is necessary to examine how other researchers have explored the use of directives by non-native speakers in institutional settings.  A small body of literature exists in this area of research.  Two studies have examined directive usage in an academic context:  one study explored uses of directives in nonprofit organizations and another study explored the use of various speech acts, including directives, in multiple workplace settings.

In one of the first large scale workplace studies to explore intercultural communication, Clyne (1994) used a corpus of 182 hours of naturally occurring conversation data to examine successful and unsuccessful intercultural communicative acts.  A unique feature of Clyne's (1994) study lies in the fact that all participants are L2 speakers of (Australian) English.  In this way, English was being used as a lingua franca or international language, a common shared code by speakers from various L1 backgrounds.  This feature contrasts with the other studies reviewed here in which intercultural communication is defined as native English speaking to non-native English speaking communication.

Table 1

*Directives empirical studies*

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Weigel & Weigel (1985) | Black male migratory agricultural laborers | Participant observations<br><br>70 interactions<br><br>98 directives in corpus | Results indicated that with this population most of the predictions derived from Ervin-Tripp's model for directive variations were contradicted.  Without regard to examined social or contextual variables, the imperative form was used almost exclusively (88%).<br><br>Weigel & Weigel proposed two possible explanations for this outcome:<br>1.  The social class and ethnic composition of this population (black, poor, migrant laborers) was markedly different than Ervin-Tripp's population (white, middleclass, profession).<br>2.  Power relationships in the community created an organizational structure that was characterized by instability (migratory) and a hierarchical structure with power in the crew leaders' hands creating a tension-filled work environment. | Used Ervin-Tripp's directives classification scheme to test hypotheses concerning the relationship between social and contextual factors (relative social status, age, familiarity, presence of outsiders, territorial location, task expectations). |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Pufahl-Bax (1986) | University office setting<br><br>Office employees | A descriptive study using quantitative and qualitative methods to analyze 64 work assignments<br>- 32 spoken<br>- 32 written<br><br><br>A comparative approach is employed examining similarities/differences between spoken and written directives | Examined the directives *orders* and *requests* and found there is a close relationship between the two types of directives that can oftentimes overlap.  In order to distinguish between the two types of directives it is necessary to consider the surrounding discursive devices, such as pre-sequences (used to check the addressee's availability) and modality markers (e.g., particles, whole propositions, and certain syntactic devices).<br><br>Spoken and written directives are organized differently and the same directive form may signal different intended meaning depending on the mode employed. | Used Ervin-Tripp's directives classification scheme to categorize directives. |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Pearson (1989) | Church business meetings at 3 different churches<br><br>12 meetings<br><br>Minister, meeting chair and ordinary group members | Discourse analysis of four church meetings<br><br>807 control acts:<br>- directives<br>- disagreement<br>- directive/ disagreement | Investigated interactions in to compare how the different roles used directives and disagreements in the meetings and as the groups tried to achieve consensus.<br><br>Ministers exerted the most control but they did so indirectly strategies in an effort to pay attention to listeners' face wants and to promote solidarity.<br><br>Chairs employed similar strategies as ministers.<br><br>It was the group members who used the most direct control act forms (70% were categorized as a direct form), primarily to disagree with other meeting attendees. | Used Ervin-Tripp's directives classification scheme to categorize directives.<br><br>Distinctive contributions:<br>1. Examined the use of directives in group interactions, as opposed to one-on-one interactions.<br>2. The study took place in a "hybrid" setting with both social and institutional characteristics, illustrating the complex relationships between linguistic choice and social roles as members work to achieve a common goal. |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| West (1990) | Medical clinic setting<br><br>Resident physicians<br>17 males<br>4 females<br><br>Patients<br>5 white men<br>6 white women<br>5 black women<br>4 black men | A descriptive study using quantitative–descriptive statistics and qualitative methods–discourse analysis<br><br>21 resident physician-patient interactions | Explored the role gender (of resident physician) played in the giving and receiving of directives.<br><br>Male residents used aggravated forms 81% of the time.  These aggravated forms consisted of imperatives, need statements, and want statements.  The use of these forms heightened the status difference between resident and patient.<br><br>Female residents used mitigated forms of directives.  West called female direction-giving "proposals for joint action" (p. 98) instead of directives due to their more collaborative nature (e.g., "Let's do, "we can").  Therefore, proposing rather than giving direction reduced the physician-patient status difference.<br><br>West showed that patients' responses to doctors' orders were highly sensitive to the ways in which directives were given.  The more aggravated the directive, the less likely a compliant response was received in return. | Used Goodwin's (1980) previous work directive usage to guide analysis of data. |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Koester (2006) | Various institutional settings (e.g., advertising, publishing, university) in UK and U.S. | Genre analysis<br><br>34,000-word corpus of institutional talk | Classified workplace discourse into different genres<br>- decision-making<br>- negotiating<br>- procedure and directive giving<br><br>For directives, indirect forms were frequently used; speakers used a variety of strategies – hedges, vague language – to get the hearer to do something<br><br>Koester demonstrated the influential role genre had on forms speakers selected to enact the genre. | |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Vine (2009) | Two government departments in New Zealand<br><br>3 managers | Exploratory study using both quantitative (descriptive statistics) and qualitative methods<br><br>47 one-on-one interactions between managers and subordinates | Examined which social and discourse-level contextual factors, if any, attributed to variation in directive use.<br><br>Social context:<br>Purpose of interaction contributed to variation in directive use.  Interaction purpose affected the frequency, density, and the ways in which directives were expressed.<br><br>Discourse context:<br>Vine examined directives' surrounding utterances and found factors associated with direct and indirect directive form usage:<br>Direct forms (e.g., imperatives) were used in the following situations:<br>1.   at the end of a long discussion<br>2.   when there were multiple tasks<br>3.   when directly elicited (usually as a question)<br>4.   in the case of NOW directives.<br><br>Indirect or mitigated forms were used:<br>1.   when the directive was isolated<br>2.   when there was a high level of imposition<br>3.   when a different approach was being suggested. | |

Table 1 (Continued)

| Author/Year | Setting/Participants | Methodology | Major Findings | Notes |
|---|---|---|---|---|
| Halbe (2011) | Military office setting<br><br>Participants:<br>- Commissioned officers<br>- Sergeants<br>- Privates | Questionnaires (n=42)<br><br>Interviews (n=19)<br><br>Observations of various military activities (e.g., physical training, meetings, office talk) | Halbe found that the linguistic strategies used were by "no means as rigid or formal as expected" (p. 332). Politeness was quite pervasive but her data analysis revealed power and social distance overruled considerations of politeness.<br><br>Directives<br>Used frequently by superiors to subordinates employing various forms and degrees of directness (e.g., imperative, *can you do*).<br>Common strategy:<br>Need statements–*I need you to…(for me)*<br><br>Advice<br>Common strategies:<br>*I recommend you to…*<br>*It is in your best interest to…*<br><br>Suggestions<br>Mitigated forms were used most frequently so as not to be perceived as face-threatening acts.<br>Positive politeness strategies were used mainly toward peers. | |

In the study Clyne (1994) analyzed various speech acts: directives, commissives, complaints, and apologies. Focusing on directives, Clyne (1994) found both direct and indirect uses of directives. However, Clyne also found that the male participants, for the most part, used direct forms to get their workmates to do something. Sometimes politeness markers, such as *please* or other downtoners, were used.

Examining matters at the conversational level, Clyne (1994) found a close interaction between speech act realizations and turn-taking procedures (p. 202). In addition, he also found cultural variation in the ways these discourse strategies were undertaken by the participants. Consequently, given the intercultural nature of the interactions, cultural variation played a role in the success or failure of the communication (p. 91). Thus, the significance of Clyne's (994) study rested with his detailed examination of the interplay between language and culture as revealed through a microanalysis of intercultural interactions. Furthermore, as regard interactions that occur in the workplace, his research makes clear that "each cultural group will use their own discourse patterns to cope with the power structures of the workplace in order to save their own face in terms of their own cultural values" (p. 203).

Taking a different approach to the examination of intercultural communication, Yates (2005) examined an academic setting to determine the ways in which Australian (NS) and Chinese (NNS) teachers used directives in the classroom. The aim of the study was to investigate and compare the strategies used by the NS and NNS teachers to mitigate the force of directives. Overall, Yates found that the Chinese teachers used less mitigation strategies for directives as compared to Australians. Additionally, the Chinese teachers tended to use a mitigation style that showed less solidarity. Australians regularly addressed positive face needs of inclusion and belonging by choosing forms that reduced social distance. The Chinese teachers

did not tend to use these strategies but rather used formal politeness markers such as *please*.  In

other words, the Chinese teachers did not seem to reduce social distance to adopt a more "matey"

stance (p. 79).  In conclusion, Yates' determined that both Australian and Chinese teachers

showed individual variation as to the mitigation strategies and styles they used when giving

directives.

In another study focusing on intercultural communication in an academic context,

Reinhardt (2010) employed a mixed methods approach to investigate international teaching

assistants (ITAs) spoken directive usage in training situations and in comparison with native

English speaking academic professionals using the context of office hour consultations.

Examining directive usage quantitatively, Reinhardt used corpus analysis and two different

corpora–a learner corpus and the Michigan Corpus of Academic Spoken English (MICASE)–to

conduct a comparative analysis between ITA learners and "expert" academicians.  Qualitatively,

Reinhardt analyzed survey and interview data to create "individual learner profiles" (p. 102).

The comparative corpus analysis showed differences in directive usage between ITAs

and practicing academic experts.  The learners showed a tendency to use directive constructions

that restricted listener choice (e.g., *you had better, I recommend, I suggest*) or promoted

dependence, and less use of constructions that promoted inclusion.  The analysis also showed a

wide variation of directive usage by both ITAs and experts; however, evidence suggested that the

ITAs relied on smaller repertoires of directives in their spoken interactions (p. 105).  Reinhardt

surmised these tendencies may be due to (lack of) instruction or exposure, or to the influence of

individual L1s and backgrounds (p. 100).

To complement his quantitative findings, Reinhardt presented three narrative sketches of

ITAs to demonstrate how their attitudes about authoritarian/egalitarian teaching styles,

awareness of language choices, and understanding of contextual factors influenced their directive

usage styles.  Through his methodological choice, Reinhardt created a comprehensive but

nuanced picture of the ITAs' directive usage patterns and the sociocultural factors that affected

their development and usage.  Viewed in aggregation, the corpus analysis revealed the directive

usage patterns of the ITAs as a group and how these production patterns compared to native

speakers in a comparable context.  Furthermore, the corpus analysis, coupled with the

ethnographic data, demonstrated individual variation of directive usage and the social and

contextual factors that contributed to these differences.

In a different institutional context, Perren (2008) employed ethnographic methods to

explore directives used during instruction giving and receiving between non-native speakers of

English and their native English speaking supervisors.  Perren (2008) conducted his study in two

nonprofit organizations.  He utilized naturally occurring data and Ervin-Tripp's (1976) directives

classification scheme to create a "detailed directive typology" (p. 317) of directive usage as well

as relevant contextual factors (i.e., task complexity, group configuration, physical conditions)

affecting usage.  Notably, ambiguous directives, in the form of hints and imbedded directives,

lead to unclear instructions and the inability of the L2 users to understand instructions (p. 151).

Additionally, interviews and field notes informed the study to provide an account of L2 English

users' perceptions of the ways directives are used in English.

Following these previous researchers, this study will examine directive usage taking an

intercultural communication approach.  As previously noted, both Yates (2005) and Reinhardt

(2010) took a comparative approach to reveal similarities and differences between native and

non-native speakers.  However, this study is aligned with Clyne (1994) and Perren (2008), taking

a descriptive approach to explore the discourse strategies the participants employ to give

directives.  Taken together, these studies showed how cultural and individual variation played a role in the styles and strategies study participants used to perform directives to students, colleagues, and subordinates.

Additionally, this extant body of research also represents various participant groups and institutional contexts.  Clyne (1994) examined a variety of intercultural interactants in various Australian workplaces, Yates (2005) and Reinhardt (2010) examined teachers in an academic context, and Perren (2008) explored volunteers' use of directives in a nonprofit context.  This study will fill an essential gap by focusing on a different population–IMG residents – and context–medical encounters.  As these previous studies focused on directive usage in intercultural contexts have highlighted, cultural-specific discourse patterns, individual variation, linguistic missteps, and ambiguous direction-giving have real-world consequences for interactants.  This is no more true than in the medical institution where interactions between physician and patient can literally have life or death consequences.  Importantly then, examining the ways in which IMG residents give directives have necessary and consequential implications for both medical and intercultural communication.

*Studies focused on advice giving in medical encounters.*

As previously noted, advice giving, which is a type of directive, is the central focus of this study because it is anticipated that IMG residents will be getting patients to do something in the treatment advice phase using this type of directive.  Two advice-giving studies have been conducted in a healthcare setting involving nurses interacting with patients and first-time mothers.  In one such study, Heritage and Sefi (1992) examined interactions between health

visitors[8] and first-time mothers in Great Britain.  The content of the interactions pertained to the health and welfare of the baby and mother approximately 10 days after delivery.  The interactions took place in the first-time mother's homes and the interactions sometimes included third-party interactants, such as the infant's father or grandmother.  In a somewhat similar context, Leppänen (1998) examined interactions between district nurses and patients in Sweden. District nurses in Sweden provide "preventive public health work and routine sick care" (Leppänen, 1998, p. 211).  The aim of both studies was to examine the ways in which advice giving was initiated in the interactions and the ways in which the advice was received.  An important contextual distinction between these two studies is that in Leppänen's (1998) study, in most cases, patients had some type of medical problem in need of treatment advice.  Whereas in Heritage and Sefi's (1992) study, the first-time mothers, for the most part, were not seeking any particular forms of advice.

In regard to advice initiation in Heritage and Sefi's (1992) study, health visitors initiated advice-giving sequences more frequently than mothers. These advice sequences were delivered explicitly, with authority so as to project relative expertise, and concerned a preferred course of future action (p. 368).  In Leppänen's (1998) study, district nurses initiated advice after a medical problem became discernible either through direct observation or through patient talk (p. 221). Heritage and Sefi (1992) found that advice was delivered using three primary forms:  (a) delivered as an overt recommendation, (b) delivered as an imperative, or (c) expressed using verbs of obligation. (p. 368-369).  Swedish district nurses also used imperatives and verbs of obligation to give patient advice.  Leppänen (1998) found these forms were used when patients realized they had a medical problem but needed advice concerning a solution to the problem.  In

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[8] Health visitors are fully trained nurses who do not focus on "routine nursing tasks but rather address illness prevention, give advice on health and social problems and do case finding for other more specialized agencies" (Dingwall, 1977, as cited in Heritage & Sefi, 1992).

addition, Leppänen's data showed district nurses also use more mitigated advice-giving forms–alternatives and descriptions of patients' future actions–when patients did not appear to realize they had a medical problem (p. 235).

While relatively infrequent in Heritage and Sefi's (1992) data, requests for advice from the mother did occur. When mothers did request advice they managed the interactional sequence so as to save competence face. In other words, the mothers managed the conversation so as to portray themselves as competent and knowledgeable about the issue they raised (p. 376). To solicit advice mothers employed both direct and indirect strategies. Leppänen (1998) noted that patients initiated requests for advice in similar ways as mothers in Heritage and Sefi's study (1992). In addition, due to the fact Leppänen (1998) used video-recorded data it was also revealed that patients point to or display the body part requiring medical attention as a part of their advice-seeking strategy.

Turning to responses to advice, Heritage and Sefi noted four primary ways advice can be received: (a) marked acknowledgment, (b) unmarked acknowledgment, (c) assertions of knowledge or competence, (d) overt rejections (p. 391). Leppänen (1998) found the same types of responses in her data (p. 230). Mothers and patients employed marked acknowledgment when they wanted to indicate that the advice received was informative and accepted as such. In the Heritage and Sefi (1992) dataset the prototypical marked response was *oh right*. *Oh* served as a change-of-state token marking the prior receipt of information as "news" (Heritage, 1984) and *right* conveyed acceptance of the advice offered. Unmarked acknowledgments of advice where conveyed by mothers and patients through the use of minimal response tokens (e.g., *mhm hm*, *mm*, *yeah*), which, in contrast to marked acknowledgement, did not convey the receipt of advice as "news". Moreover, Heritage and Sefi argued that these types of unmarked acknowledgment

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responses by the mothers indicated resistance or rejection of advice (p. 398). Leppänen's (1998) data also revealed some use of unmarked acknowledgements, but they were fewer in number. In the third way to respond to advice, mothers in Heritage and Sefi's (1992) study asserted their competence by indicating they already knew the information contained in the advice or were already following the prescribed course of action. In this way, this response design achieved a form of resistance by indicating that the advice being given was redundant (p. 409). Leppänen (1998) did not address this type of response in her study. In the final way to respond to advice, mothers and patients can overtly reject the advice. Heritage and Sefi (1992) only found one instance of overt rejection whereas Leppänen (1998) found many more instances of patients rejecting nurses' treatment advice.

These two studies demonstrated the interactional complexities revealed in a type of institutional interaction between presumed experts (health visitors and nurses) and novices (first-time mothers and patients). In one context, Heritage and Sefi's (1992) data revealed that health visitors exerted their authority and expertise by unilaterally offering advice to first-time mothers, thus denying the mothers the opportunity to demonstrate their knowledge or competence. In a related context, Leppänen's (1998) data showed that the existence of a medical problem needs to be established prior to the delivery of the advice-giving sequence. The data collected for this study aligns more with Leppänen's (1998) study than with Heritage and Sefi's (1992) study. This alignment is due to the fact that the study focuses on medical encounters in which patients are presenting one or more medical problem(s). That said, both studies provide models for how advice giving and receiving adjacency pairs get played out in health-related interactions.

Directive usage across various institutional contexts has been examined in this section of the literature review with attention directed to three primary areas. Attention was paid to the

ways in which work gets directed and done between individuals who have status congruent and status differential relationships. Focus was also given to the ways in which directives are used between individuals with different L1s. Finally, primary focus was given to the ways in which advice giving acts, a sub-class of directives, are realized. In line with these studies (Heritage and Sefi, 1992; Leppänen, 1998) that examined advice giving directive sequences, the next section of the literature review is dedicated to empirical studies that have focused on the treatment advice phase of the medical encounter – the phase of the medical encounter where it is expected that advice-giving actions will occur.

**Empirical studies focused on the treatment advice phase of the medical encounter.**

As discussed in the introduction, the medical encounter can be divided into distinct phases: openings, patient's complaint, history taking and/or physical examination, diagnosis delivery, treatment advice, and closing. In this section of the literature review, the treatment advice phase of the medical encounter will be explored. Due to the fact I focus on the treatment advice phase it is prudent to explore how my study can be informed by previous research in this area. Therefore, this section will focus on the small body of literature that has specifically examined physician-patient interactions in the treatment advice phase of the medical encounter.

In acute care visits patients are ultimately seeking a solution to their medical problem (e.g., sinusitis, knee pain). The problem is typically resolved during the treatment phase of the medical encounter when the physician recommends that the patient undertake a prescribed course of action (Robinson, 2003). For instance, the physician may recommend the RICE (rest, ice, compression, and elevation) method as a form of treatment for a sprained ankle or may recommend bed rest and over-the-counter medication for the common cold or influenza. The

treatment advice phase typically follows immediately after or in conjunction with the diagnosis delivery phase (Byrne & Long, 1976; Heath, 1992; Robinson, 2003).

Increasingly, health care policy makers and medical associations are encouraging physicians to involve patients in treatment decisions, which is congruent with a patient-centered approach to medical care (Emanuel & Emanuel, 1992). Research suggests that the rationale to encourage patient involvement in the treatment decision-making process is prompted by two considerations: patients' rights and desires to participate in the treatment decision (e.g., Ende, Kazis, Ash, & Moskowitz, 1989; Thompson, Pitts, & Schwankovsky, 1993) and patients' improved outcomes when they participate in decision making, including satisfaction, overall health, and mental well-being (Brody, Miller, Lerman, Smith, & Caputo, 1989). A small body of research examining how this decision-making process gets played out in physician-patient interactions has emerged.

In one such study, Collins, Drew, Watt, and Entwistle (2005) analyzed treatment advice interactional sequences that occurred between patients and physicians in two medical specialties (primary care and ear, nose, and throat oncology) in the UK. Using conversation analysis and focusing solely on the physicians' side of the interactions, the analysis revealed a continuum of approaches physicians took when involving patients in the decision-making process that ranged from "bilateral" to "unilateral". Physicians that took a "bilateral" approach used involvement strategies that "actively pursued patients' contributions, providing places for the patient to join in, and building on any contributions the patient makes" (p. 2626). In contrast, physicians that took a "unilateral" approach used conversation strategies that limited patients' contribution to the decision-making process. Overall, Collins et al.'s (2005) analysis showed that physicians tended to consistently use either a "bilateral" or "unilateral" approach during their patient interactions.

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In addition and despite some physicians' attempts to use involvement strategies associated with the "bilateral" approach, Collins et al. (2005) data revealed that patients' participation in decision making is limited. Patients tended to make limited contributions toward decision making and what they did contribute did not always influence the treatment plan (p. 2626).

Following Collins et al. (2005), Ijäs-Kallio, Ruusuvuori, and Peräkylä (2011) examined the "unilateral" end of the decision-making continuum. Instead of focusing on the physician side of the interaction, Ijäs-Kallio et al. (2011) focused the examination lens on patients to discover how they responded to this type of treatment delivery. Conducted in Finland, the study comprised 26 adult and 27 child patient consultations where the presenting problem was upper respiratory tract infection. Ijäs-Kallio et al. (2011) found that patients participated in unilateral treatment decision making by responding minimally or by producing extended responses, which sometimes initiated decision negotiations. Minimal responses were most frequently found and consisted of tokens, such as *yeah* and *mhm hm*. In addition, many times patients remained silent. Consequently, by remaining silent or responding minimally, patients, in essence, removed themselves from the decision-making process, thus guaranteeing physicians' "unilateral" authority (p. 148). In a minority of instances, Ijäs-Kallio et al.'s (2011) data demonstrated that patients did participate in decision making through their use of extended responses. Extended responses took the form of positive assessments (e.g., *well, that's exactly what I thought*) or responses that initiated a negotiation of a decision. Through these extended responses patients claimed their right to assess and state their point of view. In doing so they contributed and, in some instances, negotiated the treatment decision with physicians (p. 153).

Researcher Tanya Stivers has examined and written extensively on the treatment advice phase of the medical encounter (2002a, 2002b, 2005a, 2005b, 2006, 2007). In this body of work,

and through the method conversation analysis, Stivers primarily focuses on pediatric visits for upper respiratory tract infections (i.e., flu, throat, ear, or sinus infections) and the ways in which parents negotiate a prescription of antibiotics when it is not the physician's recommended course of treatment (Stivers, 2006 is an exception; it examines both adult and pediatric acute care visits). Thus, given this specific focus and stated interest in the (over)prescription of antibiotics in pediatric visits, it is clear that her study results cannot be generalized to my study. However, it is also clear that her productivity in this research area and insightful analysis and contributions into how the treatment phase gets enacted cannot be overlooked. Consequently, I shall review her research in brief here.

Stivers (2005a) examined the ways in which physicians deliver their treatment recommendations and parents' responses to these recommendations. Treatment recommendations are deemed important from the parents' perspective because they provide actionable next steps (p. 956). Furthermore, as discussed earlier, some research suggests patients and parents require validation that their symptoms and visit were "doctorable" and indeed in need of treatment (Heritage & Robinson, 2006). However, as Robinson (2003) points out, treatment activities may not always be realized because the patient's presenting problems may not be diagnosable or treatable (p. 31). Nonetheless, both patients and physicians orient to and make relevant reaching, sequentially speaking, the treatment phase and consider it one of objectives of a medical encounter.

Stivers (2005a) identified and examined two delivery formats physicians used: (a) recommendations *for* a treatment and (b) recommendations *against* a treatment. Recommendations for a treatment were found to be most frequent (82%) and were delivered using formulations such as *I'm gonna give him some cough medicines*. Taking an opposite

approach, but in a minority of cases, physicians delivered treatment by stating what they were not going to do, for example *I don't think he needs antibiotics, cause it wouldn't work.* Consequently, how treatment recommendations were formulated affected parents' responses. Stivers' data demonstrated that recommendations against treatment oftentimes engendered parental resistance. "This was accounted for because this format failed to provide parents with an affirmative next action step as a solution to their child's problem" (p. 959). Thus, Stivers concluded specific, affirmatively formulated treatment plans were more likely to secure parental acceptance (p. 962).

As alluded to above, the treatment phase is a negotiated process between physician and patient or patient's parent. This negotiation can be deemed smooth and straightforward in cases where patients accept physicians' treatment recommendations. Contrarily, the negotiation can be regarded as problematic in cases where parents show resistance to treatment recommendations. Stivers (2005b, 2006) examined the "more problematic" end of the negotiation spectrum to show how patients and patients' parents passively and actively resist physicians' treatment recommendations.

As noted above, the sequential structure of the treatment phase of a medical encounter comprises at least two phases: the physician's recommended course of treatment followed by the patient's acceptance or rejection of the treatment recommendation. Stivers (2005a, 2005b) suggested a normative structure of the treatment phase, which requires that parents ultimately accept treatment recommendations so that the next phase of the medical encounter, the closing, can begin (See Ijäs-Kallio et al., 2011 for an alternative reading). Stivers (2005b) showed that treatment recommendations are routinely accepted with responses such as, *okay*, *alright*, *let's do that*, or *that's fine*.

On the other hand, when patients or patient's parents take issue with or do not agree with the treatment recommendation, they withhold acceptance. Stivers (2005b, 2006) showed that patients withhold acceptance by using passive or active resistance. Stivers (2006) tells us that "resistance can be understood as a communication practice through which parents can, intentionally or unintentionally, place pressure on physicians to alter their treatment recommendation" (p. 299).

Passive resistance took the form of silence or the use of minimal response tokens. In these cases, Stivers demonstrated how the physician pursued the parent's or patient's acceptance through a multitude of means, including "offering a rationale for the recommendation, offering evidence for the underlying diagnosis, returning to the examination findings, and offering concessionary future actions" (Stivers, 2005b, p. 47). Responses that exhibited active resistance served dual roles; they served as responsive actions and they made relevant a next action on the part of the physician. In other words, in the next turn of talk, the physician was in a position to persuade the patient to accept the treatment recommendation or negotiate an alternative course of action. Active resistance took the form of questions, accounts, or proposals for alternative treatments (Stivers, 2005b, p. 52). Active resistance compelled physicians to use the same strategies they employed when resisted passively. However, Stivers also demonstrated that patients (or parents) used active resistance to explicitly request or negotiate a prescription for antibiotics. In these instances, which occurred in a minority of cases, parents crossed over into the medical domain and, through interaction, demanded that physicians alter their treatment course to prescribe antibiotics. In some instances, patients (or parents) "won" the negotiation and physicians prescribed antibiotics.

In his dissertation Koenig (2008) examined treatment advice in primary care visits and focused on treatment recommendations for newly prescribed medications. Koenig (2008) argued that the treatment advice phase typically consists of multiple stages: "giving ancillary advice, medication counseling, arrangement making for future contact, and instruction giving for newly prescribed medication" (p. 1). Viewed as multiple stages then, Koenig (2008) argued that the physician's treatment recommendation was simply the first of many stages comprising the treatment advice phase. Moreover, following Stivers (2005b, 2006), Koenig (2008) viewed the physician-patient interactions of this medical encounter phase as negotiated endeavors. When recommending a new medication, the physician was proposing a candidate treatment to which the patient must agree. Patient rejection, indicating a lack of preference for the recommendation or a lack of understanding about the treatment regime, must be taken up and dealt with by the physician (p. 2).

Taken together, these empirical studies provide evidence for what a conversation about treatment advice between physician and patient looks like. Through the use of the research method conversation analysis and numerous conversation excerpts, the researchers illustrated how the sequential actions of talk accomplished the treatment advice phase. Through this research method and the turn-by-turn analysis of talk, the features of this phase are revealed as it becomes evident how treatment advice is given and received in the medical encounter. Moreover, as this study will use a similar research method to analyze IMG resident-patient interactions, this literature directly informs this study. The import of this study lies with the fact that it will demonstrate how IMG residents give treatment advice to patients, a physician population not previously examined in this area of research.

Moreover, the studies demonstrated the different communication strategies, "bilateral" or "unilateral", physicians used to recommend treatment (Collins et al. 2005; Ijäs-Kallio et al., 2011) and the different forms, either *for* or *against* treatment, they took (Stivers, 2005a). In line with the discourse methods used, the researchers also explored patients' responses to treatment recommendations. They found that patients responded in different ways; most often they responded minimally but in other instances they rejected or resisted physicians' recommendations as a way to negotiate and sometimes alter the recommendation. Overall, these studies showed how "both patients and physicians oriented to the treatment recommendation as a bilateral process" (Heritage & Clayman, 2010, p. 174) in which the physicians make proposals and patients accept or reject them. This small body of research presented the treatment advice phase as a negotiated activity that gets played out linguistically and sequentially in different ways. In the end, the studies that view the treatment advice phase as a negotiated, co-constructed process inform this study given the fact it too will take a co-construction approach. How IMG residents manage treatment negotiations with patients is under investigation in this study.

**Empirical studies focused on international medical graduates' communication and language skills.**

As mentioned previously, approximately one-quarter of all physicians practicing in the U.S. are IMGs (Educational Commission of Foreign Medical Graduates Annual Report, 2010; Whelan, 2006). IMGs bring to U.S. medical institutions considerable diversity in terms of medical background and education, clinical skills, understanding of the U.S. health care system, and communication and interpersonal skills (McGrath, 2004; Whelan, 2006). As IMGs acclimate to the U.S. medical environment they may encounter such difficulties as learning cultural and social norms of the medical institution and community, adopting and displaying

professional acumen, and acquiring the necessary linguistic skills to communicate with both patients and colleagues (Cordella & Musgrave, 2009; Hoekje, 2007).  Moreover, the extant literature on IMG residents shows that they have faced some challenges that are important to review so that they may inform this study.

The literature related to IMGs is a heterogeneous body of empirical studies conducted primarily in the fields of medical education and health sciences.  In addition, some studies have also been disseminated from the disciplines of communication and applied linguistics.  Research coming from health science or medical specialty journals (e.g., *Family Medicine*) has focused on prior educational experiences (Kales et al., 2006; Searight & Gafford, 2006), IMGs' current patient care experiences (Fiscella, Roman-Diaz, Lue, Botelho, & Frankel, 1997), poor academic performance in the U.S. (Bates & Andrew, 2001), comparisons to U.S. medical graduates (Kales et al., 2006; Mick & Comfort, 1997), perceptions of an orientation program for IMGs (Curran, Hollett, Hann, & Bradbury, 2008), and communication skills (Dorgan et al., 2009; Hall et al., 2004; Jain & Krieger, 2011).  The broad range of topics appears to demonstrate not only the elevated attention researchers have paid to this unique group of residents in recent years but also highlights the range of issues requiring empirical examination.

In this section of the literature review I will focus specifically on empirical studies that examine IMGs' language and communication skills.  Further, this review of the literature will be restricted to studies that take a qualitative or discourse analytic approach, which aligns with the methodology used in this study.  Due to the fact the study focuses on language, previous research, which examines IMGs' communicative and interpersonal abilities and their experiences, perceptions, and challenges concerning patient interactions and integration into residency education can provide valuable insights to inform this study.

Methodologically, researchers have used a variety of qualitative and discourse analytic approaches to examine current and previous educational experiences, particularly those experiences related to communication skills training, and to explore IMGs' perceived, simulated, and actual communication strategies and concomitant challenges during patient interactions. Interviews with IMGs completing residency training was a method used to explore past learning experiences (Searight & Gafford, 2006), their perceptions of barriers to communication with patients (Dorgan et al., 2009), and the communication strategies used to overcome language and cultural barriers (Jain & Krieger, 2011). Fiscella et al. (1997) used two different qualitative approaches, written narratives and a focus group, to assess the "transcultural challenges" (p. 112) IMGs face when providing patient care. Using a case study, Hall and colleagues (2004) employed a variety of qualitative methods (e.g., interviews, focus group, surveys) to assess IMGs' communication skill needs. Erickson and Rittenberg (1987) and Cordella and Musgrave (2009) employed discourse analytic methods to analyze IMGs' interactions with patients.

### *Medical education and health science studies.*

Searight and Gafford (2006) examined IMG residents' prior education related to behavioral science education[9] in order to determine possible curriculum modifications in a family medicine residency program. Based on their observations and informal discussions with IMGs, Searight and Gafford surmised these were skills not commonly taught in medical schools outside of the U.S. Taking a qualitative approach, they interviewed ten IMG residents from a wide variety of countries. Their analysis resulted in several common themes, such as training in medical interviewing, their understanding of the physician-patient relationship, and their perceptions of family life in the U.S. (p. 164). As a result of the interviews, the family medicine

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[9] Behavioral science education is a widely used term in family medicine that "encompasses traditional psychiatric diagnosis and treatment, interview skills, and physician-patient interaction" (Searight & Gafford, 2006, p. 164).

residency program incorporated several of the interviewees' suggestions including modifications

to their orientation program, the introduction of a new behavioral science rotation, and

observations of faculty-led clinical encounters (p. 169).

Dorgan et al. (2009) used interviews with 12 IMG residents in three different family

medicine residencies to explore their perceptions of possible barriers in their interactions with

patients. The IMG residents' perceptions revolved around two main barriers: educational

barriers and interpersonal barriers. As regard educational barriers, most participants indicated

they had not had a communications course(s) as a part of their undergraduate medical education.

Rather, for the most part, their education was dedicated to "hard" sciences. In terms of

interpersonal barriers, the IMG residents noted several contributing factors. New or unfamiliar

cultural norms and expectations sometimes led to "uncomfortable" (p.1570) interactions with

patients. Unfamiliarity with the regional (i.e., Appalachian) dialect presented some challenges.

The difference in the physician-patient power dynamic, as compared to their home country, led

to some problematic patient encounters. Finally, many participants commented on their need to

adjust communication styles in an effort to establish rapport with their patients.

Taken together, both educational and interpersonal factors served as barriers to

communication with patients. Dorgan et al. (2009) study's findings suggest that factors shaping

communicative actions are multilayered. Moreover, by underscoring the relevance of previous

educational experiences, specifically the lack of communication education by some IMG

residents, Dorgan et al. (2009) highlight the need for residency program directors to become

familiar with their IMG residents' backgrounds and previous experiences. As the findings of this

study suggest, it is a false presumption to expect that all residents, IMG or domestic, have

received prior education in communication skills; therefore, additional attention needs to be devoted to this area as a part of the resident's graduate medical education.

Also using a family medicine residency program but focusing on both domestic (i.e., American) and IMG residents, Fiscella et al. (1997) examined the intercultural challenges residents face when providing care to patients. They used two different qualitative approaches to assess the issues culture and language played during patient interactions. The first qualitative approach consisted of residents writing a narrative (n=10) about their experiences when culture, language, or values either positively or negatively affected their ability to deliver care (p. 113). The second qualitative approach, conducted immediately following the written narrative, consisted of a 10-person focus group discussion. The analysis of the written narratives revealed how language and culture were factors in residents' feelings of acceptance, rejection, frustration, and anger. The focus group analysis revealed themes of inability to provide emotional support or caring to patients due to language barriers and difficulties in being able to express themselves. Similar to Searight and Gafford's (2006) study, the findings led the residency program to implement changes to their orientation program, to their residency support group, and also to the skills trained during specific rotations. In each of these areas, issues related to culture and language received attention so that residents felt better prepared when these issues surface, either directly or indirectly, during patient interactions.

Jain and Krieger (2011) examined communication strategies IMG residents used with patients during medical encounters. Jain and Krieger (2011) interviewed 12 IMG residents to answer the question: "What communication strategies do they use to minimize differences in language, emotion, and culture when communicating with their US born patients?" (p. 99). Using communication accommodation theory and the notion of convergence as a theoretical

framework, findings revealed that their participants used several accommodation strategies to show convergence and sometimes divergence with the communication styles of their patients. Linguistically, IMG residents used such verbal strategies as employing North American pronunciation, learning and using slang, and using repetition to accommodate for differences in their accents (p. 100). Additionally, the participants stated they used several verbal and non-verbal strategies to manage the emotional aspects of a medical encounter. The non-verbal strategies they used were: a supportive touch, eye contact, and respectful silence. Active listening and calm, reassuring tones were verbal strategies the participants stated they employed to handle emotional patient encounters (p. 101). Differences in cultural norms also played a role in the participants' abilities to accommodate their patients in their new host country. Partaking in small talk with patients, understanding physician-patient power dynamics, and disclosing diagnostic and treatment information to patients instead of family members were some of the specific cultural activities the IMG residents stated they learned to accommodate in order to converge with their patients' cultural norms.

The significance of Jain and Krieger's (2011) study, especially when examined through the lens of accommodation theory and convergence and when viewed from the macro-perspective of U.S. culture concurrently, is that many of the communication strategies used by the IMGs may appear simple, straightforward and, as a consequence, be taken for granted. The fact of the matter is that when viewed from outside a particular cultural group, communication strategies are no longer viewed as the norm. Rather, when individuals are expected to interact in a new cultural norm, as IMG residents are expected to do during medical encounters with patients, different communication strategies and styles must be learned if effective communication is expected to take place. Consequently, Jain and Krieger's (2011) study has

important implications for this study in particular and practical implications for medical education highlighting the essential fact that not all IMG residents will converge with the communication styles of their patients in the host country.

### *Applied linguistics studies.*

A small amount of research originates from the field of applied linguistics. This body of research focuses on actual linguistic realizations and how IMGs' communication styles and strategies may or may not compare to native speakers. Interpretation, inferencing, and framing are some of the topics that are explored.

Cordella and Musgrave (2009) examined 11 IMG physicians' performance on an objective structured clinical examination (OSCE) in preparation for the Australian Medical Council exam. The OSCE scenario tested the IMGs' ability to manage a patient who had been diagnosed with bowel cancer and who has refused further treatment. The researchers were interested in how IMGs articulate empathy when delivering bad news. Indeed, a bowl cancer diagnosis can certainly be termed "bad news", thus the delivery of this type of bad news is likely to be communicatively challenging, particularly for IMG physicians.

Their data analysis, relying on techniques associated with conversation analysis and interactional sociolinguistics, revealed three discourse strategies used by IMGs resulting in displays of empathy: (a) the use of positive reassurance immediately following the delivery of bad news, (b) responding to emotionally-charged words as a way to co-construct the event or align with the patients' lexical choices, and (c) one aspect of conversation turn-taking – longer than expected pauses between speakers caused by misinterpretation of turn-taking cues leading to potential communication breakdown (p.138). Cordella and Musgrave (2009) argued that those candidates who communicated effective empathy, and as a consequence scored well on the

OSCE exam, displayed both medical knowledge and effective interpersonal communication. Taken together, these two elements work synergistically, allowing the IMG to perform within the medical agenda and to show empathy (p. 138).

Gumperz (1982), in a chapter in his book *Language and Social Identity,* was one of the first studies to examine the oral production of an IMG physician[10]. In this study Gumperz presented the case of Dr. A., a Filipino doctor who, after treating a child for burns but failing to detect and report the child's parents for abuse, found himself accused of perjury. The child ultimately died. A child abuse case went to court and Dr. A. testified for the prosecution. However, after only receiving a conviction for manslaughter, the District Attorney (DA) indicted Dr. A with perjury because the DA found some inconsistencies between Dr. A's sworn testimony in the child abuse trial and written reports taken immediately after the child's death.

Gumperz was brought in as an expert in the perjury case. He conducted a linguistic analysis, specifically examining Dr. A's comprehensibility. In his presentation of the analysis, Gumperz focused on grammatical and prosodic qualities of Dr. A's oral production and how these contextualization cues affected others' ability to "correctly" infer Dr. A's intended meaning, which sometimes led to misinterpretation. Grammatically, Gumperz found that when Dr. A. was compelled to discuss cognitively more complex topics, "incidences of linguistic oddities increased" (p. 171). He also found that as a Filipino-English multilingual, Tagalog and Aklan, the other languages Dr. A. used, influenced his speech in English, which was characterized by odd uses of tense, ungrammatical expressions, and atypical grammatical choices used to link clauses. Gumperz pointed out that at a discourse level these choices lead to

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[10] It is clear from the background information Gumperz gives about Dr. A. that he is an IMG physician; he received his medical training in the Philippines. However, what remains unclear in Gumperz's detailed account of Dr. A. is whether, at the time the incident occurred, he may be classified as a resident physician or whether he had already completed his residency training. Given the uncertainty of his status, I refer to him as an IMG physician.

incoherence, particularly to a monolingual English speaker.  He further stated that "what counts as coherent in discourse depends on the range of interpretive options interactants recognize, on the frames of reference they adopt, and on how they use them to select among possible interpretations and eliminate sources of ambiguity" (p. 178).

The joint issues of communication and interpretation, or in this case, miscommunication and misinterpretation, were the main arguments of Dr. A's defense.  The majority of the jurors accepted the argument and Dr. A. was acquitted of perjury.  Though Gumperz analyzed and presented just one case, that of Dr. A., the significance of his work in light of the seriousness of the perjury charge underscores its importance. Cross-cultural misunderstandings, of course, occur frequently but when they result in being taken to court the seriousness cannot be adequately underscored.

Taking a discourse analysis approach, Erickson and Rittenberg (1987) explored the notion of topic control within the medical encounter to demonstrate how physicians use specific linguistic and discursive practices to control conversation topic while talking with patients.  As Erickson and Rittenberg (1987) aptly pointed out, the medical encounter is a complex communicative event in which the patient presents the problem, often in narrative form, the physician actively listens to track and interpret the key points of the patient's narrative and the physician takes notes for future reference.  The medical encounter is "a complex finely-tuned process of self-presentation when done correctly and adeptly.  When done ineptly, it is a source of pitfalls, for the risk of loss of face is high" (Erickson & Rittenberg, 1987, p. 406).

The authors presented three different medical encounters to demonstrate, through a turn-by-turn analysis of the encounter, how IMG residents control topic.  Their analysis showed how IMG residents use interruption to cut off narrative presentations, utilize close-ended questions

requiring a simple yes or no answer, and overlap patients' utterances to cut off answers or redirect topics. Erickson and Rittenberg (1987) argued that IMG residents desire to maintain tight control of the conversation was influenced by two different types of cultural knowledge: the interactional and communicative competence required to conduct a medical encounter with patients and cultural differences and beliefs concerning physician and patient roles (i.e., authority, how information is exchanged, appropriate topics) (p. 405). Taken together, this highly complex and culturally specific speech activity presents challenges for IMG residents. Consequently, Erickson and Rittenberg's (1987) research demonstrates that IMG residents enact certain discursive practices to help them deal with these challenges and, in turn, help them maintain face during interactions with patients.

Additionally, the authors pointed out that the medical encounter, which typically occurs in a hospital or medical office examination room, is not a conducive environment "to learn new cultural patterns through experience" (p. 413). The medical encounter is a difficult speech activity through which to learn the socially and culturally appropriate ways of speaking and interacting with patients due to the invisible nature of cultural conventions. These cultural conventions are made invisible to the IMG resident given the medical encounters' private, closed-door setting and the unlikelihood of a patient, given the asymmetrical relationship between the two roles, directly pointing out a physician's interactional infelicities. Therefore, IMG residents are often left in the dark as to the quality of their interactional performances with patients, thus pointing to a need for focused learning opportunities using observation, videotaping and feedback sessions, and assessment and training (Dorgan, et al., 2009; Eggly, Musial, & Smulowitz, 1999).

*Summary of findings about IMGs' communication and language skills.*

It is important to note that none of the studies reviewed above, except Gumperz (1982), suggested that discrete English skills or correct form usage were factors in the communicative successes or lack thereof in medical encounters with patients. Rather, taken together, the results of these studies reveal the significant role of social and cultural backgrounds and their subsequent influence on language use and interpretation. Of particular note, the sociocultural norm that IMGs noted as different between their home and host country is the power dynamic between physician and patients (Dorgan et al., 2009; Erickson & Rittenberg, 1987; Jain & Krieger, 2011; Searight & Gafford, 2006). It is understandable why the topics of power and asymmetry also surfaced in the IMG literature given varying interpretations of power and differing understandings of patient and physician roles based on cultural norms. Therefore, as previously discussed, the power relationship between physician and patient is a common theme in the literature.

In addition to sociocultural factors that affect IMGs interactions with patients, these studies' findings noted that educational background also played a significant role (Dorgan et al., 2009; Searight & Gafford, 2006). These studies demonstrated how differences in educational backgrounds, with regard to process and content, influenced IMGs' residency experiences and attributed to challenges they faced. Many IMG residents noted that their previous education placed emphasis on science education but lacked specific courses on communication skills, especially related to interviewing skills. In addition, IMG residents revealed their previous education provided scant content coverage of mental health issues resulting in IMGs feeling underprepared to handle issues (e.g., depression, anxiety) when they faced actual patients.

Interestingly, the ability to provide emotional support to patients was an issue that was discussed across multiple studies (Cordella & Musgrave, 2009; Fiscella et al., 1997; Jain & Krieger, 2011). Jain and Kriegers' (2011) participants discussed the verbal and non-verbal strategies they said they employed when interactions with patients turned emotional. Recognizing the difficulty IMG physicians may have bridging potential differences between the IMGs own sociocultural norms and the sociocultural expectations of the host country as regard empathy, Cordella and Musgrave (2009) specifically examined IMG physicians' linguistic realizations of empathy. Though Cordella and Musgrave's (2009) study used standardized patients in a simulated examination context, their findings are nevertheless significant because they presented a turn-by-turn analysis of the actual discourse features the IMGs employed to handle the emotional aspects of a medical encounter. Thus, this detailed analysis provided evidence for how some IMGs actually accomplished empathy and how others do not.

O'Grady (2011) tells us that no matter a physician's language or cultural background, IMG physician or not, displays of empathy are challenging for most physicians (p. 59). The participants in Fiscella et al. (1997) study support this claim due to the fact that the dominant theme discussed by both IMG and domestic residents in their focus group interview was their ability to provide emotional support to patients. Consequently, these studies support the notion that "empathy is a recurring theme in teaching clinical communication within the profession of general practice" (O'Grady, 2011, p. 43).

Jain and Krieger (2011) added to the literature about IMGs by presenting the general communication strategies IMG residents used in interactions with patients. Meanwhile, Cordella and Musgrave (2009) employed a discourse approach to show the successful and unsuccessful communication strategies IMG residents employed to display acts of empathy in simulated or

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examination contexts.  Overall, IMG residents employed multiple communication strategies, such as using North American pronunciation and colloquial terms (Jain & Krieger, 2011) to help them adjust to and converge to their patient's communication style, which over time could help in building rapport with their patients (Dorgan et al., 2009).  In contrast, Erickson and Rittenberg (1987) showed that during medical encounters IMGs may use other communicative strategies, such as topic control, to help them manage "interactionally difficult" (p. 405) speech events.  However, it is important to point out this discourse management strategy may have some negative outcomes such as alienating or hindering rapport building with some patients.  Notably, Gumperz (1982) extends the discussion of intercultural communication to demonstrate how communication strategies and the interpretation of the communication, through the use of contextualization cues (e.g., lexical choice, prosody), is culture bound.  The case of Dr. A. is an exemplar of an intercultural communication situation in which mismatches in interlocutors' linguistic and cultural backgrounds prevented them from sharing the same contextualization conventions through which interpretative inferences are made.  In this case, the lack of shared interpretative frames of reference resulted in misinterpretation of Dr. A's communicative intent, which almost landed him in jail.

The studies reviewed in this section have direct implications on this study signaling the need to explore further how IMG residents use language in socially and culturally appropriate ways with their patients. Therefore, this study extends the small but growing body of literature concerning IMGs, their communication strategies, and use of language while interacting with patients.  The majority of studies reviewed in this section relied on interview data to inform their studies.  For instance, Jain and Kriger (2011) used data from interviews to expand our understanding of the communication strategies IMG residents use in medical encounters.  While

their study relied on what IMG residents purportedly do during intercultural interactions, this study reports what IMG residents actually do. In this way, this study follows the few reviewed studies (e.g., Cordella & Musgrave, 2009; Erickson & Rittenberg, 1987) that examined authentic or simulated interactional data. And while these few studies begin to portray what IMGs do in interactions with patients, a more comprehensive and up-to-date analysis with real patients is needed. In this study I used naturally occurring language of interactions that take place between IMG residents and patients. In this way, the results showed what IMG residents do in authentic environments while interacting with real patients.

In this section the theoretical framework of pragmatic competence as operationalized through the institutional discourse, the notion of activity types, and (im)politeness were discussed. Additionally, the literature review informing this study was presented. The theory and empirical studies related to the speech act of directives, empirical studies on the treatment advice phase of the medical encounter, and empirical studies on IMGs' language and communication skills received primary focus. In the next chapter the methodology that was used to conduct this study will be presented.

# CHAPTER THREE: METHODOLOGY

The methodological approach that was used to analyze the spoken interactions between IMG residents and patients during the treatment advice phase of the medical encounter was discourse analysis. An eclectic blend of multiple discourse analytic approaches was utilized to analyze the interactional data and to attend to the four research questions guiding the study. As presented in chapter one, the four research questions are:

1. During interactions with patients, what are the organizational and structural features of the treatment advice phase of medical encounters?

2. In the treatment advice phase, what directive strategies do IMG residents use?

3. What is the relationship between the nature of the directives and patients' responses, including expressed likelihood of following the IMG residents' treatment advice?

4. In what ways is relational work used to manage (im)politeness in IMG resident-patient interactions?

To address the research questions, different analytic approaches were used to analyze different features of the discourse produced between IMG residents and patients. The organizational and structural features of the treatment advice phase, the advice-giving and responding adjacency pairs, and the relational work used to manage (im)politeness was analyzed to describe how the treatment advice phase was negotiated between IMG residents and patients.

Turning to the methodological framework for the study – discourse and discourse analysis – it is widely realized and accepted that discourse has been variously defined due, in part, to the number of academic disciplines that have historically been interested in examining

discourse (i.e., linguistics, anthropology, education, sociology, philosophy, political science, to name just some disciplines) (Fasold, 1990; Gee, 2010; Jaworski & Coupland, 2006; Schiffrin, 1994). Moreover, many of the different approaches used to conduct a discourse analysis originate from different theoretical and ontological starting points; consequently, a common definition, understanding or explanation of discourse is fraught with difficulty.

Nevertheless, one common way to define discourse is to emphasis its "language in use" properties (Brown & Yule, 1983; Fasold, 1990). Viewed through a discourse perspective, language is not a neutral medium through which information and knowledge is transmitted. Rather, language in use constructs knowledge, shapes practices and experiences, and generally explicates society itself. Jaworski and Coupland (2006) further refines the notion of "language in use" by stating that "discourse is language use related to social, political and cultural formations–it is language reflecting social order but also language shaping social order, and shaping individuals' interaction with society" (p. 3). Therefore, discourse is about creating a relationship between language and sociocultural context and in order to analyze discourse it is necessary to situate the language used into a wider sociocultural context.

An additional view of discourse that informs the methodological approach of this study comes from Schiffrin (1994). In *Approaches to Discourse* Schiffrin (1994) describes and compares six different discourse analytic approaches. Additionally, she demonstrates how each approach conceptualizes discourse in different ways and makes different assumptions about what should or should not be analyzed. In the end, however, Schiffrin (1994) concludes that what unites the six different approaches is the idea of "language as social interaction" (p. 414). Thus, through social interaction, one person has an effect on another; consequently, through the interlocutors' use of "both linguistic and social resources" (p. 417) a discourse is co-constructed.

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Emphasizing both the social and linguistic aspects of discourse, Schiffrin (1994) concludes discourse analysis should view "language as an activity embedded in social interaction" (p. 415).

These two general perspectives on discourse provide but a brief glimpse into how social meaning is created in and through language. Taken together, these two views of discourse–language in use and language as social interaction–are used to illuminate my understanding of the interactions between IMG residents and patients. In other words, the language each interactant uses during the course of the medical encounter is embedded in and viewed through the lens of a wider social context.

To conduct an analysis of language in use, in this case the language of the treatment advice phase of the medical encounter, requires a focused analysis of the structure of a spoken text, an examination of the various linguistic (and paralinguistic) forms used, and an exploration of the subtleties of implied meaning. Through this multi-layered analysis of the discourse's structure, forms, and functions, interpretations into how these discourse features are used to manage relations between IMG residents and patients can be made. The remaining sections of this chapter present the research design, setting, participants, data collection and analysis procedures, as well as issues of validity and reliability, and my role as researcher.

**Research Design**

This study employed a discourse analytic approach to examining naturally occurring spoken discourse. Specifically, the study relied on authentic, institutional discourse of IMG resident-patient interactions. Consequently, naturally occurring interactional data were collected and analyzed.

Further defining naturally occurring talk, Bardovi-Harlig and Hartford (2005) describe it as "spontaneous authentic language use by speakers who are speaking as themselves, in genuine

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situations, with socioaffective consequences" (p. 13).  Historically, L2 pragmatics researchers

have utilized both quantitative and qualitative research designs and have employed a wide

variety of elicitation methods to collect data[11] (Bardovi-Harlig, 2010; Golato, 2003; Kasper &

Dahl, 1991; Kasper & Rose, 2002).  However, some researchers have seen a need to explore

different research methods.  Discussing the tension between controlled or authentic techniques,

Kasper and Dahl (1991) conclude, "Clearly there is a need for more authentic data, collected in

full context of the speech event" (p. 245).

Due to the fact this study focused on language production, in other words what IMG

residents and patients did during the medical encounter, collecting authentic spoken discourse

data was invaluable.  The use of authentic, naturally occurring talk has become a recent method

of choice for L2 pragmatics researchers (Bardovi-Harlig & Hartford, 2005; Ellis, 2008; Kasper,

2006).  As Bardovi-Harlig and Hartford (2005) state "The fundamental nature of the very object

of study – language use – argues for the study of situated authentic discourse" (p. 7).  In

comparison to other similar ethnographic methods, such as observation and field notes, the

recording of naturally occurring talk allows the researcher to capture and subsequently analyze

the detailed verbal interactional attributes–syntactic structure, overlaps, interruptions, discourse

markers, silence, and so forth–associated with talk.  Using these other methods, which rely on

memorization and rapid note taking, fine-grained verbal details would likely be modified, lost, or

jeopardized by subjective decision-making about what to record.

For this study authentic discourse was situated within the medical institution and focused

specifically on the medical encounter activity type.  As Kasper and Rose (2002) tell us,

"Research on authentic speech events with nonnative speaker participants has predominantly

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[11] L2 pragmatics researchers have historically employed a relatively fixed set of data collection choices.  Among the
most commonly used are: discourse completion tasks, questionnaires, role plays, and interviews (Bardovi-Harlig &
Hartford, 2005; Blum-Kulka et al., 1989; Golato, 2003; Kasper & Dahl, 1991).

focused on discourse in institutional settings" (p. 80). The decision to utilize institutional talk, as was the decision for this study, was motivated by a number of propitious methodological factors. These factors were:

- Institutional talk takes place at a relatively fixed number of locations, thus facilitating data collection procedures.

- Given the goal-oriented nature of institutional talk (as discussed in the "Institutional discourse" and "Activity type" section in chapter two), discourse structure and conversation topics can be anticipated ahead of time facilitating the design of a focused study.

- There are real-world outcomes, or consequentiality, associated with institutional talk, thus favoring naturally occurring institutional talk as a methodological choice over other choices (e.g., questionnaires, discourse completion tasks).

- Activity types within institutional discourse can be characterized by their recurrent, routine structure. Consequently, this routineness facilitates comparisons across different occurrences of talk.

- Relatively stable social roles with one individual assuming the role of institutional representative and the other assuming the role of client also allow for comparisons across occurrences of talk (Bardovi-Harlig & Hartford, 2005; Kasper & Rose, 2002).

As discussed previously, everyday medical encounters can be classified as institutional talk (Drew & Heritage, 1992; Sarangi & Candlin, 2011; Sarangi & Roberts, 1999) and, as such, take on the defining characteristics described above. As such, a corpus of audio-recorded IMG resident-patient interactions served as the primary data source for the study.

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Interpretations of the primary data were facilitated by the use of secondary data sources. These secondary data source consisted of a post-medical encounter survey completed by patients, field notes, and classroom observation. These additional sources are described in more detail in the data source and collection procedures section below.

**Setting**

The study was conducted at a research-intensive university in the southeastern United States. Under the auspices of the College of Medicine at this institution resides Graduate Medical Education. Graduate Medical Education is the "period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty, also referred to as residency education" (Accreditation Council for Graduate Medical Education Glossary of Terms, 2011, p. 4). As of 2012, at the institution where research was conducted there were 89 accredited residency programs (e.g., Pediatrics, Surgery, Family Medicine) and 700 residents. Not all residency programs at this institution had IMG residents. Therefore, I only recruited from and worked with residency programs that had IMG residents throughout the duration of my study (See Participants section for residency programs/medical specialties that have IMG residents).

As regard the setting, the interactions between IMG residents and patients occurred in outpatient clinics where IMG residents worked and saw patients. Two different outpatient clinics served as the setting for the research. One clinic was a stand-alone outpatient clinic at the study site. The second outpatient clinic was affiliated with a local hospital.

**Participants**

    **IMG residents.**

    One of two participant populations used in this study was IMG residents. As discussed previously, IMG residents are defined as those individuals who have graduated from a medical school outside the U.S. but are completing their residency education in the U.S. at the research site. When selecting IMG resident participation for this study, one additional selection criterion was used: all IMG resident participants must have as their L1 a language other than English. The IMG resident participants represented various countries of origin and nationalities.

    In the 2013-2014 academic year there were 33 residents who were classified as IMG residents at the research site. In other words, these 33 IMG residents represented the entire population from which to select participants. Table 2 shows the various countries that are represented by this population.

Table 2

*IMG resident population countries of origin*

| Country of origin |
| --- |
| Argentina (1) |
| Azerbaijan (1) |
| Chile (1) |
| Colombia (1) |
| Germany (1) |
| Greece (1) |
| Guatemala (1) |
| Iceland (1) |
| India (6) |
| Japan (1) |
| Jordan (1) |
| Lebanon (7) |
| Pakistan (2) |
| Saudi Arabia (1) |

In addition, the population of IMG residents represents various medical specialties and residency programs. Table 3 displays the medical specialties represented.

Table 3

*IMG resident population represented Medical Specialties*

| Medical Specialty |
| --- |
| Allergy and Immunology (2) |
| Cardiology (3) |
| Family Medicine (5) |
| Gastroenterology (1) |
| Hematology/Oncology (4) |
| Infectious Disease (2) |
| Nephrology (3) |
| Neurology (7) |
| Pediatrics (1) |
| Rheumatology (2) |
| Surgery (3) |

### *Recruitment of IMG residents.*

Recruitment of IMG residents occurred in the following medical specialties: Hematology/Oncology, Infectious Disease, Neurology, and Rheumatology. I selected these residency programs because each program had more than one IMG resident in the program. Consequently, working with these programs maximized my recruitment reach by increasing the opportunity to work with more IMG residents. The following steps were used to recruit IMG resident participants:

1. Prepared a one-page summary of the research study, including research purpose and methods, participation commitments, study risks, and benefits (see Appendix A). This one-page research study summary was used for recruitment purposes. The target audience was program directors and IMG residents.

2. Once the study received IRB approval, I began contacting the residency program directors of the medical specialties noted above. Program directors served as gatekeepers to the research site and IMG resident participants. Therefore, it was important to receive permission from them to recruit the potential IMG resident candidates from their residency program. In all cases, this initial contact with the residency program director occurred via email. In the correspondence, I briefly stated my desire to conduct research with one or several of their IMG residents and the one-page research study summary (noted in step one) was attached. In addition, in two instances I conducted a face-to-face meeting with program directors. In each of these meetings, the study purpose and data collection methods were discussed in greater detail. In all four cases noted above, the program directors allowed permission to directly recruit their IMG residents.

3. Once permission was received from the program directors, the next step was to make contact with the IMG residents directly. At this stage, even though permission had been given by the program directors, it was still necessary to directly recruit the IMG residents to secure their willingness to participate. Below is a brief summary of how direct IMG resident recruitment transpired for each of the medical specialties:

   a. Hematology/Oncology – prior to recruiting the IMG residents it was necessary to secure IRB approval associated with the clinic site where the program director suggested the research be conducted. IRB approval was sought, however it was denied. Therefore, recruitment was stopped with this medical specialty.

b. Infectious Disease – I worked with an individual known as a program coordinator to contact the Infectious Disease IMG residents. After several months passed and numerous attempts were made by the program coordinator to secure IMG resident participation, I stopped recruitment with this program due to lack of willingness, although unstated, to participate.

c. Neurology – The program coordinator served as the main recruitment agent. The program coordinator provided me a list of potential Neurology IMG residents with whom I could work. From there, I made arrangements to attend clinic on a specified date. During the first clinic visit several of the potential IMG residents were in attendance. Here, I directly recruited the participants who met the selection criteria. Three Neurology IMG residents were recruited and participated. Each IMG resident participant signed the resident consent form.

d. Rheumatology – Recruitment of Rheumatology IMG residents, of which there were two, took different approaches. In one instance, I set up a meeting with the IMG resident through the program coordinator. In this meeting, we discussed the purpose of the study and data collection methods. Informed consent was received and we set up a potential date to start working together to collect data. In the second instance, I directly recruited the IMG resident face-to-face. After receiving a verbal willingness to participate, several months passed before I had an opportunity to collect data with this IMG resident. Subsequent

communication to set up an initial data collection start date occurred via

email. A signed informed consent form was received from this

participant.

As a result of my recruitment efforts, five IMG residents volunteered to participate in the

study. Table 4 displays basic demographic information about the five IMG resident participants –

languages used other than English, medical specialty, and year in residency training.[12]

Table 4

*IMG resident sample demographics*

| IMG resident participant | Languages other than English | Medical Specialty | Year in residency training |
|---|---|---|---|
| NEJG | Spanish | Neurology | 3rd year |
| NEOK | Korean | Neurology | 1st year |
| NESG | Hindi, Marathi, & Kannada | Neurology | 3rd year |
| RHCG | Spanish | Rheumatology | 4th year |
| RHOI | Greek | Rheumatology | 4th year |

**Patients.**

Patients were also considered participants in this study. That is to say, the patients' of the

IMG residents who participated in the study served as participants. Patient participation

consisted of two components: (a) the audio-recorded interactions with the IMG resident and (b)

the results they provided on a written survey (See "Data sources and collection procedures"

section below). Originally, I proposed using two selection criteria for patient participation: (a)

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[12] As a note, the two IMG residents from the Rheumatology medical specialty are in their fourth year of training. Having completed their primary training in general Internal Medicine, they are completing fellowship training in the sub-specialty of Rheumatology. I highlight this distinction because in Chapter four I make the distinction between resident and fellow in my transcription.

patients are adults, which is defined as 18 years old or older and able to provide written informed

consent and (b) patients are classified as new to the IMG resident or clinic site. However, the

second selection criterion was dropped early in the data collection period. When I started

working with the first IMG resident it was determined there was a paucity of new patients at the

clinic site where we were collecting data. Consequently, time in the field could be greatly

expanded if new patient visits remained a part of the selection criteria. Therefore, early in the

data collection phase I collected some follow-up visit interactions. After analyzing these data, I

determined that the follow-up visit interactions contained treatment discussion and advice;

therefore, the patient selection criteria were modified to include both new and follow-up visits.

The interaction between IMG resident and their patient was audio recorded if the patient

gave consent to participate in the research study. In other words, if the patient did not consent to

the recording of the interaction then I did not record it and the encounter was not included in my

dataset (see "Primary data" section below for a discussion of how patient informed consent was

received).

**Honorarium**

Honoraria were given to both participant populations as a token of appreciation for their

willingness to participate in the study. Patients received an honorarium for their participation in

the study that consisted of a $25 gift card to a local or national retailer. At the conclusion of the

medical encounter interaction and after completing the survey (in interactions in which patients

took the survey), patients received their honorarium. In some instances, patients refused to

accept the honorarium. IMG residents also received an honorarium. This honorarium consisted

of a $50 gift card to a local or national retailer or in kind honorarium.

**Review Board and Participants' Consent**

Once the proposal of my study was approved by my dissertation committee, consent to

conduct research was sought by the university's internal review board (IRB). I began the IRB

process immediately following the proposal defense in December 2012. Due to the fact research

was conducted at two different clinical sites I sought and received approval from two different

interval review boards. Following standard IRB procedure, all participants were required to sign

a consent form prior to participating in the research study. Participation consent was required

from the IMG residents and patients. I received participation consent from each IMG resident I

worked with prior to collecting data with them and their patients. The procedures I used to

obtain patient participation consent were explained previously in the "Participants" section. (See

Appendix B for IRB approval letter).

**Data Sources and Collection Procedures**

**Primary data.**

The primary data source for the study was audio-recorded naturally occurring talk of

medical encounters between participating IMG residents and patients who sought a medical

consultation at the institutional study site. The talk between IMG resident and patient, which

occurred in a clinic examination room, was recorded using a digital recorder. The entire medical

encounter between an IMG resident and patient was recorded.

Primary data consisted of 31 IMG resident-patient interactions. These interactions were

collected between April 2013 and November 2013. In the proposed study I had anticipated

requiring approximately five months of fieldwork, beginning in February 2013 and ending in

June 2013. The data collection phase took longer due to several factors. The recruitment process

proved more challenging than originally anticipated in terms of amount of time needed and IMG

residents' willingness to participate.  Recruitment halted mid-May through August, thus

extending the data collection phase.  In addition, the number of hours needed in the field to

collect data was greater than expected, resulting in the longer data collection phase.

A total of 52 hours was spent in the field collecting the interaction data.  In the proposed

study, I anticipated spending 20 hours in the field.  Table 5 displays the data collection schedule.

For each IMG resident participant, the table displays the months and number of hours in the field

and the number of interactions.

The data collection intervals, in other words the number of hours spent working at a

clinic site on a given day with an IMG resident and their patients, varied in length.  The shortest

data collection interval lasted 1.5 hours.  The longest data collection interval was 4.5 hours.  The

number of recorded interactions also varied during each data collection interval.  In some

instances, zero interactions were recorded during a data collection interval.  The maximum

number of interactions recorded during one data collection interval was five.

Table 5

*Data Collection Schedule*

| IMG Resident | Time frame | # of hours in field | # of interactions |
|---|---|---|---|
| RHOI | April and May 2013 | 18 hours | 12 |
| NESG | September and October 2013 | 6 hours | 4 |
| NEOK | September and October 2013 | 9.5 hours | 4 |
| RHCG | October and November 2013 | 12 hours | 9 |
| NEJG | October 2013 | 6.5 hours | 2 |
| **Total:** | | **52 hours** | **31** |

*A typical IMG resident-patient interaction.*

As mentioned previously, I worked at two different clinic sites to collect the interaction data.  Though some variation occurred from site to site, a routine procedure was established and used during each data collection interval and for each IMG resident-patient interaction.  The following data collection procedures were utilized:

1. Clinic schedules were divided into AM sessions or PM sessions.  If I were working with an IMG resident in the AM session, I would arrive at the clinic to start working at 8AM; if I were working with an IMG resident in the PM session I would arrive at the clinic to start at 1PM.  After arriving at the clinic, I would wait until either the IMG resident or the nurse told me that a patient had arrived and was in an examination room.

2. Patient informed consent to participate in the study took place in the examination room before the medical encounter began.  Two different formats were used, which depended on the IMG resident's readiness to see the patient.  If the IMG resident was ready to see the patient and begin the medical encounter we would enter the examination room together.  If the IMG resident was not ready to begin the examination of the patient, I would enter the examination room alone to begin the informed consent process.

3. The informed consent process with the patient consisted of the following details:

    a. Introduced myself and my role;

    b. Described the study and what it was and was not about;

    c. Informed the patient that the discussion with physician(s) would be audio recorded, that I would remain in the examination room to observe, and, at the conclusion of the medical encounter, the patient would take a short survey (see Secondary data section below);

d. Informed the patient of the participation benefits (See "Honorarium" section above);

e. If the patient consented, I would review the informed consent form in as little or as much detail as the patient wanted and needed. After this review process, the patient would sign the informed consent form.

The patient informed consent process took approximately 5-7 minutes. Willingness to participate in the study was at the patient's sole discretion. Overall, seven patients did not give consent to audio record the medical encounter. In most of these instances, patients expressed that they did not feel comfortable having the medical encounter recorded. In two instances, during the patient consent process I learned the patient spoke the same L1 as the IMG resident; therefore, the IMG resident-patient interaction would be conducted in the native language. In both these instances, patient consent was not sought. In one instance, the patient was mute. Once learning of the patient's physical and mental condition (from the social worker who accompanied the patient), the patient informed consent process was halted.

4. After patient informed consent was received, the medical encounter was set to begin. If the IMG resident and I were already in the examination room, I turned on the audio recorder to begin recording the interaction. In other instances, the IMG resident and I would enter the examination room and I would turn on the audio recorder to commence recording. All 31 medical encounter interactions were recorded from the beginning to end. The audio recorder remained on the entire time during all interactions; at no time did a patient or IMG resident request that it be turned off. In addition, I remained in the

examination room during all 31 recordings. While in the examination room I took observation notes of the interaction (see "Secondary data" section below).

5. After the medical encounter completed, the audio recorder was turned off. Thereafter, I gave the patient the post-medical encounter survey (Appendix C) to complete (see "Instrument" section below for discussion of survey completion rate). Once completed, I presented the patient with the participation honorarium. In 29 of 31 interactions, the patients accepted the honorarium. In some instances the post-medical encounter activity occurred in the examination room. In other instances, the activity occurred just outside the examination room or in the clinic waiting room.

**Secondary data.**

As previously mentioned, secondary data sources were also used. Three different secondary data sources were utilized: classroom observation, field notes, and post-medical encounter survey. In Fall 2012 I observed a communication and clinical presentation skills course that medical students (not IMG residents) at the research site are required to take as a part of their second year curriculum. A communication and interpersonal skills course for residents is not currently offered at the research site for residents; therefore, I observed a course that medical students take.

The goal of these observations was twofold. First, classroom observations served as an additional source to gain insider knowledge about the medical community and its discourse. Second, the observations provided background knowledge about how communication skills are taught, developed, and discussed within the medical community. In this way, these course observations helped to inform my understanding and interpretations of the interactions I observed and recorded.

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As mentioned in the data collection procedures above, observation field notes were taken during and after the recorded IMG resident-patient interactions. These field notes were used during the analysis phase to inform the interpretive process. (See Appendix D for Observation Notes form used during medical encounter interactions).

As an additional data source, patients completed a post-medical encounter survey. The purpose of this survey was to assess patients' perceptions of the medical encounter, including treatment recommended and their overall impressions of the level of (im)politeness of the encounter. Related to patient health outcomes, patients' nonadherence to physicians' treatment recommendations remains a major healthcare issue (Lehane & McCarthy, 2007; Levesque, Li, & Pahal, 2012). On average, researchers estimate that 50% of patients do not adhere to their physicians' recommended treatment plans (Haynes, McDonald & Garg, 2002). While there are several factors affecting patients' willingness to follow physicians' orders (e.g., personal characteristics, cognitive factors), significant factors related to this study are quality of communication and physician-patient relationships (Burgoon, Parrott, Burgoon, Coker, Pfau, & Birk, 1990; DiMatteo, Reiter, & Gambone, 1994; Levesque et al., 2012). Therefore, this study focused on these key areas–communication and physician-patient relationships–to investigate patients' immediate impressions of the completed medical encounter. Patients completed the survey after the medical encounter had ended and after the IMG resident had left the examination room.

**Instrument.**

The survey instrument contained 19 questions. Two survey questions (question 1 & 2) focused on whether the IMG resident and patient had a pre-established relationship and if so, how many times they have interacted. The next seven questions addressed treatment and asked

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the patient a series of questions concerning the way in which treatment was offered. Question

three asked if treatment was offered. If so, in question four the patient was asked to describe the

treatment offered. The purpose of asking the patient to describe the treatment offered was to

compare the actual treatment offered, as documented in the transcript, to the patient's understood

treatment recommendation to observe similarities or differences between the two data sources.

Questions five through eight gauged the patient's perceptions as to how the treatment advice

phase was conducted. For instance, questions five and six asked the patient if s/he had any

question about the treatment and question seven asked the patient to indicate if the treatment was

explained clearly. Question nine asked about the patient's likelihood, at that moment, using a 5-

point likert scale, to comply with the treatment advice given. Question ten asked the patient to

describe the interaction with the IMG residents by selecting from a number of descriptors. The

purpose of question ten was to receive patient input as to their perceptions of the interactional

relations with the IMG resident. Question 11 was an open-ended question allowing the patient

the opportunity to provide additional information about the medical encounter. The last eight

questions were related to the patient's demographics–age, gender, language, education level,

occupation, ethnicity, and race (See Appendix C for survey instrument).

As mentioned above, the patient surveys were completed at the conclusion of medical

encounter, prior to the patient's departure from the clinic. Over the entire data collection period

21 (68%) patients completed the post medical encounter survey and ten (32%) patients did not

complete the survey. The survey completion rate was lower than originally anticipated,

consequently contributing factors will be considered in Chapter five.

**Data Analysis Procedures**

The data analysis phase of the research study consisted of multiple steps and stages. Importantly, I considered this analysis phase an iterative process consisting of repetition, double-checks, fitful starts that lead to dead ends, and a reliance on previous literature to confirm, disconfirm, and compare findings. This phase consisted of multiple stages. The stages comprising the data analysis procedures are described below.

**Stage 1: Data preparation and organization.**

After the IMG resident-patient interactions were collected, all audio-recorded data were transcribed into text. As the researcher, I completed the transcription process. Completing the transcription process myself allowed me an initial opportunity to connect with the data and begin the analysis process. Following an iterative process, I commenced the transcription phase while still in the field collecting additional IMG resident-patient interactions. Additionally, due to a rather large gap of several months between commencing and completing data collection, the first set of audio-recordings were completely transcribed as I returned to the field to collect additional data.

Although the focus of my data analysis was on the treatment advice phase of the medical encounter I planned to transcribe the stretches of talk that occurred immediately before and after the treatment advice phase. A major criticism leveled at speech act theorists is that they examine utterances in isolation (See Drew & Heritage, 1992; Schegloff, 1988 for criticisms; See Blum-Kulka, House, & Kasper, 1989 for an exception). Due to the fact I followed a discourse analytic approach, I was able to head off this criticism. During the transcription process I slightly modified this plan to transcribe stretches of talk surrounding the treatment advice phase. As I began the transcription process I noticed that discussion of treatment occurred throughout

various phases of the interaction. For instance, I noticed a discussion of current treatment could

occur within the first minute of the interaction. Therefore, I modified my plan to include and

transcribe all treatment discussions no matter where they occurred within the medical encounter.

In many instances, the entire medical encounter was transcribed.

Table 6 provides some basic details about the 31 interactions I recorded and observed.

Specifically, the table displays the interaction number, the visit type, the visit length, whether the

medical encounter was transcribed, and if so, the number of pages.

Table 6

*Interaction Statistics*

| Interaction # | Visit type | Transcribed (Yes/No) | Visit length (min:sec) | # of pages |
|---|---|---|---|---|
| NEJG001 | New patient visit | No (data lost) | N/A | N/A |
| NEJG002 | New patient visit | Yes | 28:27 | 18 |
| NEOK001 | New patient visit | Yes | 37:43 | 7 |
| NEOK002 | New patient visit | Yes | 33:16 | 5 |
| NEOK003 | New patient visit | Yes | 23:43 | 6 |
| NEOK004 | New patient visit | Yes | 17:49 | 8 |
| NESG001 | Follow-up visit | Yes | 10:33 | 6 |
| NESG002 | New patient visit | Yes | 25:41 | 11 |
| NESG003 | New patient visit | Yes | 13:04 | 8 |
| NESG004 | New patient visit | Yes | 15:43 | 7 |
| RHCG001 | Follow-up visit | Yes | 25:51 | 18 |
| RHCG002 | Follow-up visit | Yes | 38:34 | 10 |
| RHCG003 | Follow-up visit | Yes | 24:32 | 18 |
| RHCG004 | New patient visit | Yes | 47:26 | 24 |
| RHCG005 | Follow-up visit | Yes | 19:19 | 7 |
| RHCG006 | Follow-up visit | Yes | 21:50 | 16 |
| RHCG007 | Follow-up visit | Yes | 36:36 | 20 |
| RHCG008 | Follow-up visit | Yes | 44:19 | 24 |
| RHCG009 | Follow-up visit | Yes | 29:39 | 15 |
| RHOI001 | Follow-up visit | Yes | 21:00 | 15 |
| RHOI002 | Follow-up visit | Yes | 29:51 | 10 |
| RHOI003 | Follow-up visit | Yes | 40:06 | 16 |
| RHOI004 | Follow-up visit | Yes | 34:16 | 19 |
| RHOI005 | New patient visit | No | 25:42 | N/A |
| RHOI006 | Follow-up visit | Yes | 37:13 | 18 |

Table 6 (Continued)

| RHOI007 | Follow-up visit | No | 30:41 | N/A |
|---|---|---|---|---|
| RHOI008 | Follow-up visit | Yes | 27:48 | 17 |
| RHOI009 | Follow-up visit | Yes | 28:01 | 14 |
| RHOI0010 | New patient visit | Yes | 44:26 | 20 |
| RHOI0011 | Follow-up visit | Yes | 17:05 | 14 |
| RHOI0012 | Follow-up visit | Yes | 25:28 | 17 |
| **Avg.** | | | **28:31** | **13** |
| **Total:** | | | **14 hrs 15 mins** | **388** |

The total hours of audio recordings is14 hours and 15 minutes with an average visit length of 28 minutes 31 seconds.  The number of transcribed pages is 388.  Table 6 shows that there was variation in the number of audio-recordings collected per IMG resident.  With participant NEJG I was able to collect only two interactions.  With participants NEOK and NESG I was able to collect 4 interactions each and with RHCG and RHOI I was able to collect 9 interactions and 12 interactions, respectively.  Overall, in the dataset there were 19 follow-up visits and 12 new patient visits.  Three audio recordings were not transcribed.  One recording was not transcribed because the data was either lost from the audio recorder or the record button was not depressed when the medical encounter was about to begin.  One recording was not transcribed because no treatment was given during the medical encounter.  Instead, various labs and tests were prescribed to help determine a diagnosis.  The third recording was not transcribed because there was no modification to the current treatment plan (prescription of Plaquenil to treat lupus).  This interaction differed in that in all the other transcribed interactions either a new treatment plan was given to the patient or a modification to an existing treatment plan was negotiated between the IMG resident, attending physician, and patient.

The transcription system and coding conventions I used follows Jefferson (1979). See Appendix E for conventions and description. In the transcripts pseudonyms were used for people and places to protect confidentiality of all participants in the interactions.

**Stage 2: Data analysis.**

After preparing the transcripts, I began the analysis process from which emerged the findings presented in Chapter four. I quickly moved into this phase of the research because early in the process I was invited to give two different presentations on various aspects of the study and data. One presentation primarily focused on the data collection process and preliminary analysis of data and the second presentation was an adaptation of research question four and focused on the relational work the participants used to co-construct and manage the interactions. I mention these two presentations here because they served as motivation to me to swiftly move into this arguably intimidating and overwhelming phase of the research process. The opportunity to present a preliminary analysis of the data, without being heckled off the stage so to speak, provided me with the confidence necessary to move forward knowing that I was not completely off track with my analysis.

The first phase of the process consisted of an analysis of each transcript. I decided it was necessary to analyze all 28 transcripts, one by one, to see what the interactional data showed. Highlighting, underlining, making notes in the transcripts' margins, and using color-coded stickies to indicate the research question addressed through a stretch of talk was the method I used. In addition, I maintained a document to note random "analysis ideas" as they came to me throughout the process.

After the initial analysis phase completed, I utilized a methodical approach to analyze and answer each research question. Turning to the research questions, I decided that it made good

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analytical sense to first answer research question two (In the treatment advice phase, what directive strategies do IMG residents use?)  I made this decision due to the fact research question two directly addresses the main theme of the study.  To help organize the treatment advice sequences found in the data, I used a table to document and categorize all instances (from both IMG resident and attending physician) of treatment advice giving.  Thereafter, I used the table to identify, code, and classify the linguistic features associated with treatment advice giving.

After completing the analysis and write-up of research question two, I reanalyzed the data to answer research question one (During interactions with patients, what are the organizational and structural features of the treatment advice phase of medical encounters?).  In comparison to the analysis of research question two, the analysis of research question one required a macro-level approach to determine the structural and organizational features that defined the overall medical encounter and treatment advice phase.  As will be presented in Chapter four, the analysis for research question one primarily focused on the features that uniquely define these data to make meaningful contribution to the literature on the treatment advice phase.

Next, I answered research question three (What is the relationship between the nature of the directives and patients' responses, including expressed likelihood of following the IMG residents' treatment advice?).  The initial approach was to utilize each of the extracts presented in research question two to analyze how the patients responded to the treatment advice given. However, a reanalysis of the patient response data revealed that there were some interesting interactional features to present.  Consequently, a sole reliance on the previously presented excerpts proved inadequate.  In addition, it was necessary to answer the second part of the research question, which is:  the patients' expressed likelihood of following the IMG residents' treatment advice.   To answer this question, it was necessary to utilize the post-medical

encounter survey data. After considering different approaches to answer research question three, I decided to present several different excerpts (different from those presented in research question two). Additionally, I used two questions from the post-medical encounter survey to triangulate and provide supporting evidence about the patients' expressed likelihood to follow the treatment advice.

I completed the analysis process by answering research question four (In what ways is relational work used to manage (im)politeness in IMG resident-patient interactions?). The analysis of this research question extended beyond the treatment advice phase and included an analysis of the entire transcript to find acts of relational work (e.g., humor, empathy, small talk). Again, a table proved useful. I used this table, of which a modified version is presented in Chapter four, to record the participants' different acts of relational work. Next, the discourse strategies the participants used to co-construct the acts of relational work were analyzed for signals of face-enhancing, face-maintaining or face-challenging behavior (Locher, 2006; Locher & Watts, 2005; Watts, 2003). As Watts (2003) advises, in order to reach an interpretation "the researcher needs to carry out a fine-grained, sensitive analysis of verbal interaction relying heavily on features of the context" (p. 170).

In addition to the collected interaction data, the secondary data sources comprised of the interaction observations and survey data were also used to inform the discourse analysis. The observation note worksheets were used during the analyses phases as a confirmation tool allowing me to form initial perceptions and confirm recollections of the interactions. Additionally, as noted above, I used the survey data as an interpretive tool. As will be discussed in Chapter four, two questions from the patient survey, question four and nine, served as supporting evidence to assist in the interpretation of the data. In addition, these survey data were

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used in determining the patients' likelihood of following the treatment recommendation. Thus, these multiple data sources–interaction transcripts, observation notes, and survey data – were used collectively in this data analysis stage to guide the interpretative process.

**Validity and Reliability**

I shall now turn to the task of addressing validity and reliability issues raised in the study's theoretical and methodological approaches. One way in which the study's soundness has been established is by grounding it in a theoretical framework. Due to the fact any discourse analysis is an interpretative act, in which multiple interpretations can emerge, underpinning the interpretative process in a theoretical framework provides a sound basis for the interpretation (Crowe, 2005).

Additionally, due to the fact discourse analysis was the method employed in the study, Gee (2010) informs us that two notions–"convergence and linguistic details"–are important aspects of validity when working in this tradition (p. 124). In order to address convergence, in other words the ability to demonstrate compatible or convincing arguments through multiple examples, the number of interactions collected as a part of data collection is sufficiently large enough to yield multiple discourse examples. Moreover, in Chapter four I will show several interaction excerpts as a way to demonstrate convergence and support my claim. As regard linguistic details, I conducted a rigorous linguistic analysis, as demonstrated in the "Data Analysis Procedures" section above, so that "the communicative functions being uncovered are linked to grammatical devices that manifestly serve these functions" (Gee, 2010, p. 123-124)

Construct validity or what Cicourel (1992, 2007) calls "ecological validity" is addressed via the design of the study, primarily through the use of primary and secondary data sources. The multiple data sources were used to support my interpretations and claims and provided the

best evidence about the everyday activity of the medical encounter. In addition, the design of this study employs the triangulation of data. That is, multiple sources of data are collected and utilized to inform my interpretations of the language data I analyze. In this case, the secondary data were used to inform and substantiate interpretive discoveries from the primary data, the transcribed recordings of the IMG resident-patient interactions.

As regard the second factor of reliability, it was built into the study through a conscientious attention to detail in the data collection and transcription process. High-quality, reliable recording equipment were used to record the primary data. As regard data transcription, as mentioned previously, detailed transcription conventions, required as a part of the discourse and conversation analytic methodological approach, were employed. Moreover, due to the fact one type of interactional data (IMG resident-patient interactions), as opposed to many types, were collected and analyzed, the reliability of my interpretative findings were enhanced. Reliability of my interpretations was also enhanced due to the fact the medical encounter is constrained by an identifiable structure. This type of structured event makes it possible to control for some of the variables (i.e., participants, setting, conversation topic) that can be troublesome in informal, spontaneous conversation (Agar, 1985). Additionally, comparisons across speakers and interactions were able to be made given the similarities of participant types (i.e., IMG residents and patients), setting (i.e., medical) and conversation topic (i.e., medical encounter, treatment advice) (Bardovi-Harlig & Hartford, 2005).

## Limitations and Delimitations of the Study

The descriptive findings discovered in this research were limited to the setting and population under study. That said, it is possible that the results of this study can be used to inform other studies that use a similar population or context. Moreover, while generalizability

was not the primary objective of the study, the findings provided evidence about what is discursively possible between physicians and patients during the treatment advice phase through a close examination of their interactions. This collection of data provides both theoretical insights and insights into human interaction so that we can come to a better understanding about human behavior in this medical context. In addition, the study was informed by only four to six participants at one study site. While this number of participants was sufficient to begin to paint a picture of IMG residents' directive and interactional strategies during the treatment phase of a medical encounter, it can be said that additional participants could have provided additional insights.

An additional limitation existed with regard to the data collection procedures. That is, data collection and analysis were limited to verbal interactions only. While verbal interactions provide a rich source of input for shaping understanding, this study could have been additionally informed by the use of video to record the non-verbal interactions between the participants. Taken together, both verbal and non-verbal cues provide a more complete representation of the interactions between IMG residents and patients. The main reasons for deciding not to video record the interactions was taken out of privacy concerns for the patients, logistical issues, and the increased complexity of the data analysis.

**My role as Researcher**

In this research study I bring the dual roles of both insider and outsider. As an administrator in the Graduate Medical Education (GME) office at the research site, this role privileged me with institutional knowledge regarding how residency programs function. As well, this insider role provided some privilege related to issues of access to research sites (e.g., clinics). Working for GME entails knowledge concerning whom to contact to gain access to a

site as a researcher. For instance, some of the program directors I contacted I knew from previous encounters (e.g., meetings) and others I had not met before. It was my desire that work I do for Graduate Medical Education coupled with the important work of the study for their IMG residents fostered positive relationships.

Following both my time at the research site and growing and changing responsibilities as a GME administrator, the detailed knowledge concerning the daily operations of the residency programs and the routine work lives of residents transformed and grew over time. After spending 52 hours in the field colleting data, I had a more knowledgeable and informed understanding about the "day in the life" of a resident in an outpatient clinical setting. Moreover, the daily operations of GME require me to interact frequently with residents via email, meetings, and serving on committee together. Consequently, these clinical and administrative activities provided me opportunities and experiences to inform and shape my understanding and, in turn, apply this knowledge to this research study. That said, my medical knowledge is clearly limited as I am not a medical doctor. Nor do I have detailed insider knowledge concerning how physician-patient interactions get played out. In both domains I bring a layperson's knowledge based on my personal and familial medical issues and medical encounter experiences. However, as previously mentioned, in an effort to gain additional background knowledge concerning the medical encounter, I observed a communication and clinical presentation skills course for medical students at the research site.

In summary, as a researcher my goal in this study was to shed light on how IMG residents give treatment advice to patients. Considering IMG residents are an understudied population, especially as it relates to their linguistic and pragmatic abilities, this study contributes to research on international medical graduates by demonstrating how IMG residents

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use their sociopragmatic and pragmalinguistic knowledge in their L2 to interact with patients during the medical encounter.  As physician-patient interactions continue to remain influenced by the patient-centered model, it seems that it is no longer sufficient for physicians simply to engage in an exchange of information with patients about diagnoses, treatment, and health outcomes.  In addition to the exchange of medical information, physicians now need to demonstrate a range of communicative and interpersonal proficiencies and strategies, such as empathy, humor, deference, and negotiation, in an effort to maintain positive relations with patients.  Thus, while this study contributes to multiple lines of research–physician-patient interactions, politeness, international medical graduates, advice giving to name a few areas–the main goal of the study was to demonstrate how the results of this discourse analysis can be useful in understanding the dynamics in one phase of IMG resident-patient medical encounter interactions.

# CHAPTER FOUR:  DATA ANALYSIS

Treatment for symptoms can take several different forms.  Depending on a patient's symptoms, rest, change in eating habits, exercise, or medication are some of the methods physicians use to treat a patient's aliments.  In this study, the data revealed that the physicians relied exclusively on prescription medication as the primary way to treatment their patients' symptoms.  It was not the intention at the start of this research study to focus on prescription medications.  However, as I have come to learn through my education in qualitative research, the data will reveal themselves as they may and the researcher has little to no control over the content.

As mentioned in Chapter three, the medical specialties focused on this study were Neurology and Rheumatology.  Consequently, in the 28 interactions the discussion of the patients' symptoms tended to focus on pain, swollen or stiff joints, numbness, and tingling extremities.  To treat these specific symptoms and others, the physicians turned to prescription medication to alleviate and reduce pain and discomfort associated with the patients' conditions.  As the analysis below will show much of the talk during the medical encounters focused on how the prescribed medications worked to treat the patients' symptoms.  This was especially true during follow-up visits in which patients had returned to the clinic to discuss how the current treatment was working.  Common topics of discussion involved medication dosage amounts, side effects as a result of taking the prescribed medication, and efficacy of medication.  Based on this medication discussion and when the conversation narrowed to further treatment

recommendations, it involved talk about prescribed medication, perhaps adding a new medication, or modifying the dosage, or swapping one medication for another.

In the analysis that follows I explore in greater depth this talk between physicians and patients about medications. To organize this chapter I divided it into four sections. Each section is devoted to analyzing and answering one of the four research questions.

**Research Question One**

During interactions with patients, what are the organizational and structural features of the treatment advice phase of medical encounters?

The advice giving sequence can be simple and straightforward, involving few turns, or can entail more complexity, leading to lengthy stretches of discourse involving multiple turns. Scholars previously examining the treatment advice phase have provided valuable insights into the features that define this phase of the medical encounter. For example, Stivers (2005b) has discussed the need for a patient response before the physician can move out of the treatment advice phase. Additionally, Stivers' (2002a, 2005a, 2005b) research demonstrates how treatment advice formulations for treatment or against treatment affect the unfolding of the interaction and how patient's resistance to a particular treatment recommendation can compel the physician to make alternative recommendations for medication that may in fact not be needed.

Similar to Stivers, Koenig (2008) also examined the interactional processes of giving and receiving treatment and found that a range of activities occur within the treatment advice phase. In his analysis he specifically focused on two key areas of the phase: 1) physicians' treatment recommendations and patients responses and; 2) physicians' giving of instructions for a new medication. According to Koenig (2008), these two areas of the treatment advice phase complete the interactional process and bring the activity to a close.

Building on this previous work, this section will further inform this area of research on the

treatment advice phase by examining the organizational and structural features found in these

data.

One area where these data expand the scope of previously conducted research and

provide new insights is related to the overall structure of the medical encounter. As discussed in

Chapter two, scholars examining health communication have devised a model of the

organizational structure of the medical encounter (Byrne & Long, 1976; Robinson, 2003; ten

Have, 1989; Waitzkin, 1991). In the model the medical encounter is comprised of six separate

activities (see Figure 2). As many of these scholars have noted, this medical encounter model

works for new patient and acute care visits. However, complications arise when trying to apply

the model to other visit types in physician-patient interactions.
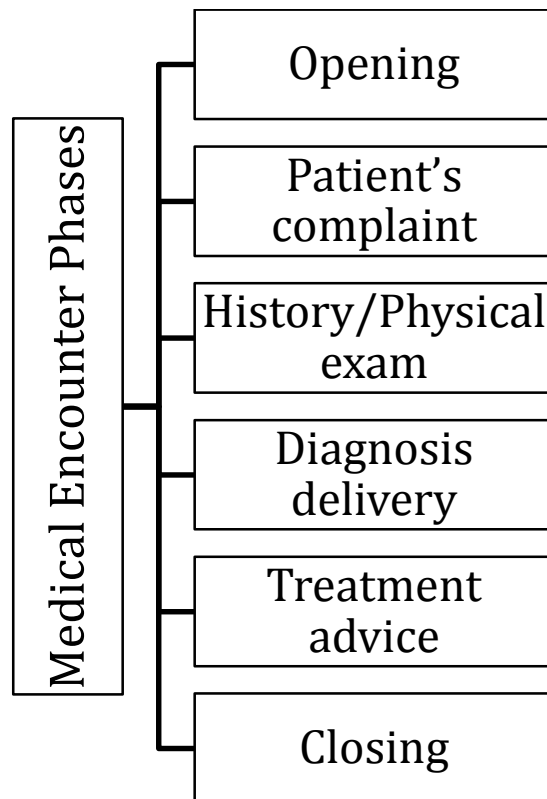
Figure 2 Medical Encounter Phases Revisited

One such visit type that poses problems to a strict application of the model is a follow-up visit. The phases of a follow-up visit remain sandwiched between the opening and closing activities but the other four activities – patient's complaint, history taking/physical exam, diagnosis delivery, and treatment advice – become optional depending on the purpose and trajectory of the physician-patient interaction. As previously noted, the data in this study primarily consist of follow-up visit interactions (18 of 28 transcribed interactions or 64%); therefore, the inability to apply a recognizable model to these follow-up visit data proved challenging when analyzing their structure (Heritage & Maynard, 2006).

The second feature of these data, which will be explored in more detail in this section, relates to the specific institutional setting from which these data were collected. As mentioned in Chapter three the primary participants in the study are IMG residents. Resident physicians assume a unique role in the clinical setting due to the fact that they assume a dual role as both learner and physician as they prepare for the independent practice of medicine. Importantly, in their role, the resident physician is under the supervision of an attending physician. As will be described below, in the clinic setting where the institution assumes dual objectives of providing both teaching and supervision to residents and patient care, the medical encounter model cannot be straightforwardly applied.

With this type of supervised medical encounter, with the attending physician supervising the IMG resident, these data show that the medical encounter can be divided into two distinct phases. In the first phase of the medical encounter the IMG resident interacts with the patient on his/her own. In other words, the attending physician is not participating in the interaction. The medical encounter commences with the opening and depending on whether the visit is a new patient or a follow-up, the IMG resident proceeds to the other activities or phases as needed.

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Henceforth, I will refer to this phase of the medical encounter as the solo interaction. In nearly all the interactions in the dataset the IMG resident will depart the exam room upon completion of the exam, thus signaling the end of this first phase.

To begin the second phase of the interaction, both the IMG resident and attending physician reenter the exam room together. In a few instances the attending physician entered the exam room before the IMG resident had completed his/her solo interaction with the patient and in a few other instances the IMG resident reentered the exam room solo and the attending physician joined the interaction several minutes later. Henceforth, this phase of the medical encounter with both the IMG resident and attending physician interacting with the patient will be referred to as the joint interaction. In this second phase, which again is sandwiched between the opening and closing phases, the other activities, such as completing a physical exam or providing treatment, are varied and do not occur in a systematic or routine manner.

In these data then the medical encounter reveals its own distinctive structure and flow which are defined by the two specific phases, what I am terming the solo interaction and the joint interaction. To provide a visual representation of the distinctive phases comprising the supervised medical encounter, the model presented in Figure 3 below provides the basic structure. As mentioned previously, the solo and joint interactions both entail opening and closing phases and depending on the type of visit, new or follow-up, the intervening activities vary. For illustration purposes, in Figure 3 these additional activities (e.g., patient's complaint, history taking) are labeled *Other activities*. Additionally, in Figure 3 *Delay* refers to the transition from the solo interaction phase to the joint interaction phase. This phase typically entailed a delay of several minutes in which the patient remained in the examination room unaccompanied by either physician.

```
┌──────────────────────┐
│  Solo Interaction    │
│       Opening        │
├──────────────────────┤
│   Other activities   │
├──────────────────────┤
│  Solo Interaction    │
│       Closing        │
├──────────────────────┤
│        Delay         │
├──────────────────────┤
│  Joint Interaction   │
│       Opening        │
├──────────────────────┤
│   Other activities   │
├──────────────────────┤
│  Joint Interaction   │
│       Closing        │
└──────────────────────┘
```
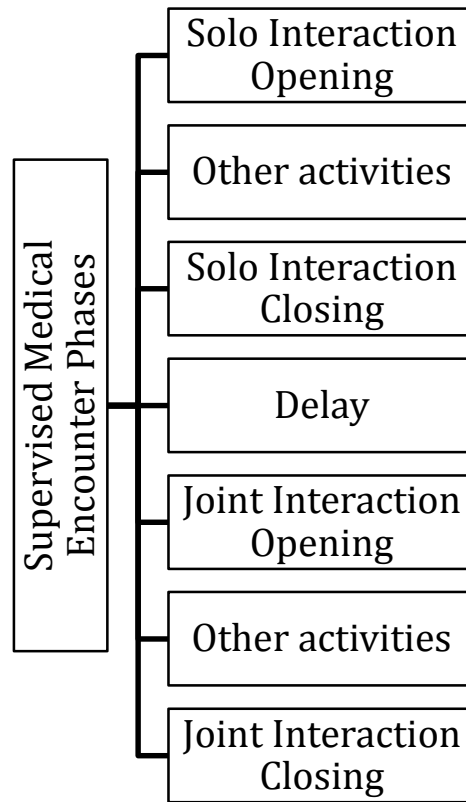
Figure 3 Supervised Medical Encounter Phases

I present the supervised medical encounter phases in Figure 3 as a high level illustration of the distinctive features found in these data. It is not meant to be a detailed representation of the supervised medical encounter but rather it serves as a visual to help build understanding of these two distinctive phases. To date, a review of the literature reveals that researchers have not addressed this rather common type of medical encounter; consequently, it was necessary to describe this phenomenon in detail.

This brief introduction to the distinctive phases of the supervised medical encounter establishes the foundation for a more in depth analysis of the activity under discussion, that is the treatment advice phase. In other words, upon establishing the groundwork for these two distinctive phases, the solo interaction and joint interaction, how does the giving and receiving of

treatment get played out in each of the phases?  Is treatment recommended in both phases or in

only one?  If only one of the phases, in which phase is treatment given?  Are there interactions in

which no treatment advice is given in either phase?   In the following section I will attempt to

answer these questions as I explore in greater detail how treatment advice is realized.

**Solo interactions.**

Examining the treatment advice phase during the solo interactions, the analysis revealed

that the IMG residents recommended treatment some of the time to patients.  The data revealed

that IMG residents give treatment advice in 16 of the 28 transcribed medical encounters, or 57%

of the time. In contrast, there were some interactions in which the IMG resident did not

recommend treatment during the solo interaction.  In 12 of the 28 medical encounters or 43%,

the IMG residents do not give treatment advice to their patients.  Given this breakdown in which

just over one-half of the IMG residents provide treatment advice, the elective or optional nature

of the activity during the solo interaction becomes apparent.

When IMG residents do give treatment advice what organizational and structural features

comprise the activity?  Taking a look at the first data extract, it comes from an interaction in the

Rheumatology clinic with a female patient diagnosed with rheumatoid arthritis.  The patient is

taking the medication Methotrexate (see "Glossary of Medications" in Appendix F for a

definition of medications and their uses).

As this is the first extract being presented from the study, I provide here a description of

how I chose to represent the data.  Throughout the paper, extracts will contain a header, which

consists of the extract number, the interaction identifier, and the patient's diagnosis, if any.  In

some instances in this section of the paper I also identify if the extract comes from the solo or

joint interaction.  The header is set off by an underline.  The extract line numbering will coincide

with the line numbers of the transcript. Each line of data consists of three parts: a) line number; b) speaker identifier and; c) speaker's discourse. Speaker's talk exceeding one line will wrap to the next line. The nomenclature used for the speaker identifiers is as follows:

- PAT is used for the patient

- RES is used for an IMG resident

- FEL is used for an IMG fellow

- ATT is used for the attending physician

- PAT HUS is used to identify the patient's husband

- PAT WIFE is used to identify the patient's wife

- PAT MOT is used to identify the patient's mother

- NUR is used for nurse

Returning to the first extract in the Rheumatology clinic, the IMG resident has just completed a multi-question exam with composite score to determine if the patient requires medication for her bones. The determination is that she does not and a short discussion ensues about contributing factors to osteopenia and osteoporosis. The IMG resident states that the patient's labs (e.g., blood work, images) look okay then he says:

Extract 4.1 RHOI009 Rheumatoid arthritis
```
101:   FEL:   so the question is if we should do something more 'bout your uhm like
102:          increasing a little bit the Methotrexate uhm
103:   PAT:   fur the wrists
104:   FEL:   yeah you still have >a little bit of:< active disease there uhm (1.5) an if
105:          you tolerate it well
106:   PAT:   uhm uh yeah
107:   FEL:   you should be okay an your labs looks great so
108:   PAT:   uhm uh mkay
109:   FEL:   let me go an find the boss
```

The treatment advice talk in Extract 4.1 consists of seven turns between the IMG resident and patient. The IMG resident initiates the treatment recommendation in line 101. Using a rhetorical

question and indirect advice giving strategies (these indirect strategies will be discussed in further detail in research question two), the IMG resident asks aloud whether the dosage of Methotrexate should be increased *a little bit*. The patient follows this treatment proposal with a question – *fur the wrists* – seeking clarification from the IMG resident that he is considering increasing Methotrexate because of the pain she is still feeling in her wrists. Not until several lines later in 108 does the patient agree with the IMG resident's recommendation to increase the medication Methotrexate. The patient says *uhm uh mkay*. We see here that the IMG resident provides several different reasons to justify his treatment recommendation: a) active disease (line 104); b) patient tolerates medication well (line 105) and; c) labs look good (line 107). This listing of justifications may be considered knowledge display on the part of the IMG resident. In other words, he wants to demonstrate to the patient that he has an understanding of how the medication affects her symptoms and in providing this list of reasons it serves to justify the increase in medication and works to convince the patient it is the proper course of action to take. Equally, this listing of justifications may have been necessary on the part of the IMG resident because the patient does not immediately give consent to the treatment recommendation. Moreover, the listing of justifications may have been needed given the ambiguous way in which he presented the treatment advice. Consequently, the IMG resident continues to hold the floor and in doing so provides the listing of justifications as a way to pursue the patient's acceptance of the treatment recommendation.

This extract demonstrates how the giving and receiving of treatment advice is co-constructed between IMG resident and patient. In this case the IMG resident makes a recommendation to increase the dosage of the patient's current medication. Formulated as a recommendation, as opposed to overtly telling the patient what must be done, the IMG resident

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seeks patient's acceptance (or rejection) of his treatment proposal.  The IMG resident provides

justification for his recommendation, serving the dual purpose of providing knowledge while

also pursing the patient's acceptance of the treatment recommendation.  In this way, the

treatment advice phase can be viewed as a shared decision-making process.

The next extract displays a more complex treatment advice negotiation between IMG

resident and patient.  The interaction occurred in the Rheumatology clinic with a patient

diagnosed with psoriatic arthritis.  The patient is currently taking Methotrexate for her arthritis.

She recently started to taper off of steroids.  Additionally, she was previously taking Humira but

stopped it after she came down with another medical condition.

Notably, this part of the interaction may not have occurred except for the fact that the

attending physician was not yet ready to join the IMG resident and patient.  The IMG resident

wrapped up her solo interaction and departed the examination room.  No treatment

recommendation was given, thus serving to illustrate the optional nature of the treatment advice

phase during the solo interaction.  However, several minutes later the IMG resident returned to

the exam room solo and continued her interaction with the patient. Approximately 40 seconds

into this second phase of the interaction the IMG resident says:

Extract 4.2 RHCG007 Psoriatic arthritis
```
160:   FEL:   how aggressive do you wanna be at this point given thatchyou don't ha-
161:          like you're only a two out of three let's say[13]
162:   PAT:   (x) I mean
163:   FEL:   would you would you be okay with waiting ta see what the Methotrexate
164:          does at this without the steroids at this point uhm
165:   PAT:   I mean I'd be willing ta give it a couple weeks but if in a couple of weeks I
166:          can't drive I mean I I can't function when I can't pick up my daughter so
167:          (PAT laughs)
168:   FEL:              [yeah then obviously you have ta
169:   FEL:   okay
```

---

[13] When the patient was previously asked to provide a numeric description of her pain based on a zero to ten scale, she said "maybe a two er a three".

170:   PAT:   and that's been what's been happening I get I can't open doors I can't do
171:          things for myself
172:   FEL:   okay it's fair that's fair (PAT laughs)

The treatment advice phase starts with the IMG resident stringing two interrogatives together

seeking the patient's input about what she wants to do with her treatment going forward.  In

contrast to Extract 4.1 in which the IMG resident vocalizes his treatment recommendation, here

in this treatment advice sequence the IMG resident indirectly offers her treatment advice (line

163 – *would you be okay with waiting ta see what the Methotrexate does*).  Coupled with this

indirect treatment advice strategy, the IMG resident also employs an alternative shared decision-

making strategy by directly soliciting the patient for her input.  Starting in line 165 the patient

provides a response – *I'd be willing ta give it a couple weeks* but makes clear across several turns

that her daily activities cannot be severely hampered by a modified treatment plan.  The IMG

resident acknowledges the patient's point of view at the end of the sequence with *okay it's fair*

*that's fair*.

        Several turns later the IMG resident poses another question to the patient with a different

treatment option.  She starts the sequence by saying:

186:   FEL:   how about uhm (1.0) so I I don't know if this is what he's gonna
187:          recommend but if he <u>does</u> recommend escalating treatment ta like an IV
188:          infusion
189:   PAT:   uhm uh
190:   FEL:   would you be able ta come in? ta do that?
191:   PAT:   I have ta come to (city name) every month?
192:   FEL:   uhm (1.5) where do you live
193:   PAT:   in (county name) county (city name) I mean I can do it I (X) I need it to be
194:          late I can't leave work eve(h)ry mo(h)nth
195:   FEL:   yeah (1.0) well I mean the the initiating the treatment is usually what's
196:          more tedious because it's like zero two on whatever weeks an but then
197:   PAT:                                                          [mhm mm
198:   FEL:   actually wh- wh one of the infusions uhm I think can be spread out even
199:          like every eight weeks
200:   PAT:   mhm mm that would (X)
201:   FEL:   but it's even every two months it's although you at first the first month

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202:   PAT:                                                    [yeah
203:   FEL:   you're gonna have ta do it a few times
204:   PAT:   uhm uh
205:   FEL:   uhm later on it will be more spread out and that one can be adjusted fer
206:          your weight
207:   PAT:   uhm uh
208:   FEL:   uhm we can actually push it a little bit closer as well if you're not
209:          responding
210:   PAT:                                                    [mhm mm
```

In this sequence the IMG resident hypothesizes what the attending physician, not she, might recommend as a treatment option. She once again seeks the patient's input. In this turn she seeks the patient's input as to whether the patient would be willing to come to the clinic to take treatment. Over the next several turns the IMG resident explains how the treatment is initiated, which perhaps also functions as an attempt to convince the patient this may be a viable treatment option. Throughout the IMG resident's explanation the patient provides minimal responses (e.g., *mhm mm*, *yeah*, *uhm uh*). In responding minimally, and as we saw in Extract 4.1, the IMG resident's turns do double-duty by providing information and pursuing patient's acceptance of this treatment recommendation. Notably, the patient provides no overt acceptance of this treatment proposal.

In comparison to Extract 4.1 this interaction demonstrates how the IMG resident utilizes an alternative communication strategy in an effort to co-construct the treatment advice phase. In the previous extract, Extract 4.1, the IMG resident opened up the treatment advice phase by recommending a treatment option to the patient. In Extract 4.2 we see that the treatment recommendations serve dual purposes: they serve as treatment options (i.e., stay the course with Methotrexate, start an IV infusion) for the patient and they also serve to directly solicit the patient's input about the proposed treatment option.

In summary, these two extracts illustrate how IMG residents give treatment advice and patients receive this advice during solo interactions. As demonstrated, both IMG residents initiated the treatment advice phase, with each utilizing a different strategy. Importantly, patient input, either directly or indirectly, contributed to and co-constructed the treatment advice sequences. Consequently, each participant shared in the treatment decision-making process. In the next section, I will explore the joint interaction phase to examine the ways in which it is structured and organized.

**Joint interactions.**

In this section I turn to the second phase of the supervised medical encounter, the joint interaction phase. It is in this part of the interaction that the attending physician joins the IMG resident and patient in a continued discussion of the patient's symptoms and healthcare needs. The data revealed that when the patient was in need of treatment advice it was always given during this phase.[14] In other words, and in contrast to the solo interaction phase, the giving of treatment was not considered optional during this joint interaction phase.

The treatment recommendations during this phase get realized in multiple ways. As presented in the two extracts in the solo interactions, the physician, specifically the IMG resident, initiated the giving of treatment. During the joint interactions, it is the case that in a vast majority of the interactions the attending physician initiates the treatment advice phase. The data also reveal that the treatment advice phase is sometimes initiated by the IMG resident and by the patient. We will look at examples of each type in which a different participant – the attending physician, the IMG resident, or the patient – initiates the treatment advice sequence.

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[14] There were three interactions in which no treatment advice was verbalized. In two instances other diagnostic tests were ordered and in one instance the patient's treatment plan did not change.

Previous research has examined the initiation of advice giving in the healthcare context (Heritage & Sefi, 1992; Leppänen, 1998). Heritage and Sefi (1992) examined interactions between health visitors and first-time mothers and Leppänen examined interactions between district nurses and patients. In both studies advice giving was initiated by either participant. However, Heritage and Sefi (1992) indicated that in their data the health visitor initiated a vast majority of the advice giving with the advice occurring after an inquiry (by the health visitor) into the health and welfare of the baby (p.389). In other words, the health visitor initiated the topic of discussion to which she gave advice. In Leppänen's (1998) study, quantification of which participant (nurse or patient) initiated more advice-giving was not reported but her data revealed that the nurses' advice-giving turns occurred immediately after patients' health issues became manifest (p. 223).

In both studies the researchers were interested in examining how advice-giving became topicalized, or in other words, what topics were previously being discussed to bring about the initiation of the advice. For instance, Leppänen showed how a patient's turns indicated a lack of awareness about the probable source of a foot wound, his diabetes, which led to advice on how to properly care for his feet. Here too in this study it is essential to examine the topics under discussion prior to the initiation of the advice giving phase. In addition, this study will build on this previous research by not only examining which topics but also which participant's turn led to the giving of treatment advice. As a result, the definition of the initiation of advice-giving being used here is modified, as compared to Heritage and Sefi's (1992) and Leppänen's (1998) studies. In this study I will more closely examine the actual turn that initiates the treatment advice sequence: who initiates it and how it is designed.

*Attending physician initiated advice.*

Similar to Heritage and Sefi (1992) and Leppänen (1998), these data show that the healthcare professional initiates the treatment advice.  This is not surprising and is in fact expected given the physician's professional role and medical expertise. As noted above, in a majority of the cases (91%) the attending physician initiates the advice giving sequence during the joint interactions.

One way the attending physician commences the giving of treatment is after a discussion of the patient's medical condition. Similar to Leppänen's (1998) study in which nurses initiated advice after medical problems had been made manifest (p. 221), some attending physicians in these data make their treatment recommendations immediately after stated observations of patients' medical problems.  In Extract 4.3 below the patient was referred to the Neurology clinic because of a recent episode of seizures.  The reason for the visit was to determine if the patient should remain on anti-seizure medication, which she was prescribed during a recent visit to the hospital.  In the talk leading into Extract 4.3 the attending physician enumerates the medical problems contributing to the patient's seizures and the fact she has a scar on her brain due to a stroke.  In this way, the attending physician's talk sets up her ensuing treatment recommendation. The attending physician starts the treatment advice sequence:

Extract 4.3 NEOK002 Seizures
```
58:    ATT:  …I would prefer to keep you on a small dose of Keppra
59:    PAT:  okay ᴼkayᴼ
60:    ATT:  because you know its it's a scar
61:    PAT:  right
62:    ATT:  an scar in the brain like I said it causes irritability an the area of the scar is
63:          actually an area of the brain that is very likely to produce seizures
64:    PAT:  oh okay
65:    ATT:  now keeping you on the medication doesn't give you a warranty that you
66:          will never have a seizure
67:    PAT:                                                              [right
68:    ATT:  but at least you know you have something in your blood that is keeping
69:          you you know
70:    PAT:                  [yeah
```

```
71:    ATT:   a a- a- kind of more steady state okay?
72:    PAT:   okay
73:    ATT:   so this is what I would recommend
74:    PAT:                    [okay alright
75:    ATT:   an if you agree then we'll do that=
76:    PAT:   =yes
```

In line 58 we see the attending physician making her treatment recommendation to keep

the patient *on a small dose of Keppra*.  The patient shows agreement with this treatment

recommendation in line 59 with okay ᴼkayᴼ.  Following the recommendation and agreement, the

attending physician continues the sequence with provisions of justifications (line 60 – *because*

*you know its it's a scar*; line 62 – *an area of the brain that is very likely to produce seizures*) for

her recommendation.  It is also notable that each of the attending physician's turns is met with a

response (e.g., *oh okay*, *yeah*, *okay alright*) by the patient.  Though minimal, the responses

appear to signal understanding if not acceptance of the attending physician's previous turns.  In

line 73 the attending physician begins to bring the treatment advice sequence to a close and in

line 75 seeks patient consent to move forward and implement the recommendation.

During the interaction from which Extract 4.3 is taken, the IMG resident makes no overt

treatment recommendation during the solo interaction.  However, during the closing phase of the

solo interaction she informs the patient that the attending physician and she will discuss to

determine whether the patient needs to be on the seizure medication or not.  Consequently, this

treatment advice, as shown in Extract 4.3, is the only one the patient receives.

In comparison, there are many occasions in the data when the patient receives treatment

advice from the IMG resident during the solo interaction and again receives treatment advice

during the joint interaction.  In these instances then the patient is presented with two treatment

recommendations.  To illustrate, I will return to a medical encounter previously examined in

Extract 4.1.  In this extract we saw that the IMG resident recommended an increase to the

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patient's current medication, Methotrexate.  Examined from a different angle, it is useful to

consider how this recommendation compares to the treatment advice offered during the joint

interaction.  Is the treatment recommendation the same or different when comparing the solo and

joint interactions?  Additionally, which physician, the attending physician or the IMG residents,

gives the treatment advice?

As the joint interaction of this medical encounter begins, the attending physician asks the

patient for input about her overall improvement since starting the Methotrexate.  Additionally,

the patient questions how rheumatoid arthritis affects her immune system to which the attending

physician provides an answer. Immediately prior to the commencement of the treatment advice

sequence, the attending physician had just completed a physical examination of the patient's

hands and wrists.  Accordingly, this activity, conducting and completing the physical exam, is

yet another way treatment advice sequences can be initiated.  Extract 4.4 shows how the

treatment advice sequence gets played out during the joint interaction.

Extract 4.4 RHOI009 Rheumatoid arthritis Joint interaction
178:  ATT:  so I think the thing that makes the most sense at this point since you
179:        tolerate the Methotrexate is go up to eight tablets which is kind of our
180:        maximum dose
181:  PAT:  mkay
182:  ATT:  hopefully that'll getcha where ya need to be and hopefully there'll be no
             new changes on the x-rays
183:  PAT:  okay
184:  ATT:  but <u>if</u> the eight tablets isn't enough ta completely get rid of it <u>or</u> if we start
185:        to see new damage on the x-rays then we might have ta ramp
186:  PAT:  alright
187:  ATT:  therapy up a little bit <u>you</u> start to get more infections or have more
188:        problems with that then call us and let us know
189:  PAT:  okay

Extract 4.4 is similar to Extract 4.1 in that the attending physician initiates the treatment advice

phase and in the next turn the patient provides acceptance.  In line 178 the attending physician

provides his recommendation to increase the Methotrexate dosage to eight tablets.  The patient

responds *mkay* to this recommendation in line 181. The attending physician projects optimism that this will get the patient where she needs to be to bring the rheumatoid arthritis under control but verbalizes the possibility that they *might have ta ramp therapy up a little bit* in the future if improvement halts or if new physical damage is detected.

Comparing the treatment recommended during the solo and joint interactions, we see that the IMG resident and attending physician are in alignment. Put another way, both physicians make the same recommendation to increase the dosage of Methotrexate. Where there is a divergence in the treatment recommendation is in the way each physician designed his turn. The IMG resident utilizes vagueness in his recommendation to increase *a little bit the Methotrexate*. In contrast, the attending physician utilizes more concrete language with his treatment recommendation to increase the Methotrexate dosage to eight tablets. However, in the end, both physicians are in agreement to increase the Methotrexate dosage.

An additional observation about Extract 4.3 and Extract 4.4 is that the treatment advice sequences occur between the attending physician and patient. That is to say, the IMG residents makes no verbal contributions to the treatment advice sequences during the joint interactions. As we will see in the extracts that follow, it is not always the case that the treatment advice sequences are jointly constructed solely between the patient and the attending physician.

In the prior section on the solo interaction phase of the medical encounter, I presented an extract, Extract 4.2 during which the IMG resident solicited the patient's input as she proposed possible treatment options (e.g., hold Methotrexate dose steady, escalate treatment to IV infusion). Turning to the joint interaction to explore and compare how treatment advice is presented during this phase of the medical encounter, the IMG resident starts this phase by presenting the patient's history to the attending physician. Next, the attending physician asks a

series of questions, which both the IMG resident and patient answer, to get a better picture of the

patient's medical condition and medication history.  As the interaction progresses to the

treatment advice phase, the topic immediately preceding the treatment advice phase is the

patient's future pregnancy plans.  As it turns out, the medication the attending physician is

considering is contraindicated with pregnant woman.  Consequently, he wants to rule out any

future pregnancies prior to making a treatment recommendation.  The treatment advice phase

proceeds as follows:

Extract 4.5 RHCG007 Psoriatic arthritis
```
325:    ATT:   so so so right now you know your're close to the three months where you
326:           wanna know if the Methotrexate had failed or not
327:    PAT:   right
328:    ATT:   and uh you are taking eight pills and looks like it has not help you at all
329:           since we started
330:    PAT:   mhm mm
331:    ATT:   uh one option is to increase it >you know you know< give it you know a
332:           few more weeks an see how it works
333:    PAT:                                                          [uhm uh
334:    ATT:   ah an then another option is to switch it to Arava
335:    PAT:   mkay
336:    ATT:   an uh it's also been very effective for psoriatic arthritis pain
337:    PAT:   uhm uh
(brief discussion about patient's shoulder pain and weakness)
357:    FEL:   so wanna start the Arava now
358:    ATT:   yeah I think we can switch the Arav- the
359:    FEL:   switch?
360:    ATT:   yeah we'll switch the from
361:    FEL:                   [okay
362:    2.0
363:    ATT:   we can start=
364:    FEL:   =twenty?
365:    ATT:   yeah s- twenty yes we can start her you know twenty milligrams is the
366:           maximum dose
367:    PAT:   uhm uh
(return to discussion of pregnancy for several turns)
394:    ATT:   so so we'll we'll try the Arava okay for the the pain the knee
395:    FEL:   mhm mm
396:    ATT:   I mean your knee this this is definitely a bit warm
397:    PAT:   uhm uh
398:    ATT:   uhm we'll try the Arava if this does not work (0.5) then we might have to
```

399:          revisit the possibility of the TNA the biologic the Enbrel
400:    PAT:                                    [um          [kay

Similar to the treatment advice phase during the solo interaction between IMG resident and patient, this phase too requires multiple turns in which the patient, IMG resident, and attending physician work jointly to complete the interaction.  In addition, two side discussions punctuate this treatment advice sequence, which helpfully divide it into three sections, or frames, serving distinct purposes.

In the first frame, lines 325-337, the attending physician recommends alternative treatment options.  The first proposed option is to *increase it*, with *it* referring to the Methotrexate medication the patient is currently taking and mentioned in line 326.  The attending physician's second treatment proposal *is to switch it to Arava*.  Between each of the attending physician's turns the patient provides minimal responses.  The IMG resident is largely absent from this section.  In other words, the IMG resident makes few verbal contributions.

When comparing the treatment recommendations between the solo and joint interactions, there is only slight alignment in the proposals the IMG resident and attending physician make.  Both physicians make the same initial treatment recommendation; that is to stay the course with Methotrexate to see how the patient continues to respond.  Deviation in treatment recommendations occurs in the subsequent recommendation.  In the solo interaction the IMG resident hypothesizes that the attending physician may recommend IV infusions, such as Enbrel, Humira, or Remicade.  However, the attending physician does not make this recommendation during the joint interaction and instead his second treatment option is to prescribe Arava.

The second frame of the advice sequence, lines 357-367, commences as the IMG resident brings the interaction back to the topic of treatment as she says *so wanna start the Arava now*.  Posed as a question inviting medical authority, this turn requires a response from the attending

physician, not the patient. The attending physician provides the response and concurs with the recommendation to prescribe Arava. In these two turns then the IMG resident and attending physician jointly construct the treatment advice. Over the next several turns the interaction continues between the attending physician and IMG resident as their talk, turn by turn, co-constructs medication dosage and whether Arava is replacing Methotrexate or being added on. The patient remains silent until the end when she provides a minimal response – *uhm uh*.

The third and final frame occurs in lines 394-400. In it the attending physician summarizes the immediate treatment recommendation and proposes a future treatment option *if this* (Arava) *does not work*. This section, once again, occurs between the patient and attending physician with the patient once more supplying minimal responses to the attending physician's statements.

This extract serves to illustrate how multiple parties work jointly to construct the giving and receipt of treatment advice. Each individual in the interaction assumed his or her institutional role as supervising attending physician, IMG resident, and patient to bring to fruition the patient's treatment plan. Additionally, this interaction demonstrates how both the IMG resident and attending physician worked together to solidify the treatment recommendation. In other words, through a series of conversational turns they co-constructed their plan for the patient. Though there was slight deviation in the treatment recommendations given during the solo interaction and joint interaction, in the end, agreement was reached and a joint treatment decision was made.

### IMG resident initiated advice.

In addition to the attending physician initiating treatment advice, the IMG resident also initiated the treatment advice sequence. As previously noted, I define the initiation of treatment

advice to mean the participant who commences the treatment advice sequence. In these data

there were two instances in which the IMG resident initiated the treatment advice sequence

during the joint interaction phase. This dataset makes this opportunity possible due to the fact

there are two physicians participating in the joint interaction. In this way, during the joint

interaction phase the possibility exists for either physician to initiate the treatment advice

sequence. I will show one of the two instances in which the IMG resident initiates treatment

advice here. The second instance will be shown below (see "Multi-party talk" section).

Extract 4.6 comes from a follow-up visit, which takes place in the Rheumatology clinic

with a patient diagnosed with psoriatic arthritis. The patient, a female, was recently taken off the

medication Arava because there was concern it may be causing the patient's blood pressure to

elevate. During this visit she presents with additional arthritic symptoms, which developed since

her last visit. Leading into the treatment advice phase during the joint interaction the discussion

focuses on the patient's current medical condition and her increased soreness and tenderness. In

the extract below the IMG resident starts the treatment advice sequence:

Extract 4.6 RHCG006 Psoriatic arthritis
```
213:   FEL:   uhm: but I was thin- like we could do the Methotrexate and the biologics
214:          or:?
215:   ATT:   [so
216:   ATT:   or you can just go straight=
217:   FEL:   =ta the biologics
218:   ATT:    [uh
219:   ATT:   yeah the Methotrexate that's still controversial if it really helps
220:   FEL:   how bout the Arava? is it the sa- like Arava (XX)
221:   ATT:   she has she was stopped right because
222:   FEL:   it it was but the thing is she's on blood eh it she's on blood pressure
223:          medication and her blood pressure has been stable
224:   ATT:   yeah
225:   FEL:   and
226:   ATT:   I don't if we can you know avoid Arava anymore because the TNFs gunna
227:          do the same job
228:   FEL:   ᴼkayᴼ
```

In line 213 the IMG resident vocalizes her recommendation for future treatment for the patient. Her recommendation consists of a combined treatment of Methotrexate and a biologic (e.g., Enbrel, Humira, or Remicade). She concludes her treatment recommendation turn with the conjunction *or* signaling the possibility that she is open to discuss alternative recommendations. Over the next two turns (lines 216-217) the IMG resident and attending physician co-construct an alternate treatment option to *just go straight ta the biologics* because, as the attending physician points out, it is controversial whether Methotrexate is beneficial (line 219). Continuing the treatment recommendation discussion, the IMG resident makes yet another medication recommendation with Arava. With this turn she poses a question – *how bout the Arava* – presumably to the attending physician wanting to know if a particular medication has the same effect as Arava. It is unclear whether the medication she is referring to with *it* is the Methorexate or the biologics. The attending physician responds with the reminder that Arava was stopped. Nonetheless, the IMG resident continues her advocacy for Arava in lines 222-223 providing justification that the patient's blood pressure is stable because she is taking blood pressure medication. She attempts to continue in line 225 but the attending physician begins a turn in the following line as he recommends that the patient continue to remain off Arava *because the TNFs* (i.e., biologics) *gunna do the same job*. The IMG resident acquiesces with a quiet *kay*.

Similar to other extracts presented previously, this section of Extract 4.6 demonstrates the co-construction of treatment advice, in this case between IMG resident and attending physician. The interaction occurs exclusively between the two physicians with the patient remaining silent. Given the content of the interaction the patient's silence seems reasonable as the physicians negotiate treatment options. Initiation of the treatment advice sequence is provided by the IMG

resident. She proposes two different treatment options: 1) Methotrexate and biologics or 2) Arava. Additionally, the two physicians jointly construct an alternative option to *go straight ta the biologics*.

This treatment advice sequence is not yet completed. As no final treatment decision has been reached the sequence continues. In the next frame and after a brief description about TNFs as a family of medications, the attending physician continues on the topic of Arava. He states:

```
233:    ATT:   yeah because uh if it has been documented before the Arava had caused
234:           you trouble
235:    PAT:   uhm uh
236:    ATT:   then probably you know because there's still a lot of options out there=
237:    PAT:   =okay
238:    ATT:   and uh it's if it's if it's on- if it's the only option then we might have to try
239:           it but there's a lot of options out there that are really good
240:    PAT:                                      [okay
```

Notably, in this section the interlocutors switch as talk occurs exclusively between the patient and the attending physician. The IMG resident does not participate even though in the previous section it was she who proposed Arava as a treatment option. In part this is due to the design of the attending physician's first turn in this section. In lines 233-234 the attending physician personalizes his reasoning for wanting to avoid restarting Arava – *the Arava had caused you trouble* – thus constraining the next turn to a response from the patient. She accommodates with *uhm uh*. The attending physician then continues in justification mode with the assessment that there are a lot of good medication options.

With this section then it appears the attending physician's talk works to accomplish the forward movement of the treatment decision-making process, likely toward the use of some other medication other than Arava. Here, the attending physician's explanatory turns coupled with the patient's minimal but agreeable responses work jointly to carry out this process. Moving into the final section where the treatment decision is made, there is a shift in framing as the attending

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physician and IMG resident discuss the patient's labs (not shown here).  Next, the attending

physician returns the topic of conversation to the patient's future treatment as he starts this

section of the extract with the following turn:

```
248:   ATT:   you can do either it's your you know if you want TNFs
249:   FEL:   uhm
250:   ATT:   like Humira Enbrel so so because you say it's (0.5) will be easier fer you
251:          to get it you know injecting it yourself at home? or you wanna come here?
252:   PAT:                                              [no that's no I can do it
253:          myself
254:   FEL:   so let's just do the Enbrel
255:   ATT:   yeah we can stave the Stelara for second (X)
256:   FEL:   (if needed if XXX)
257:   7.0
258:   ATT:   ᵒokayᵒ
259:   PAT:   now I know the Enbrel is uhm (1.0) is a biologic s- that's still uh a- uhm
260:          still cause auto (0.5) deficiency er? no?
```

With the medication Arava now out of the picture as a possible treatment option, the

remaining viable option remains TNFs.  In lines 248 and 250 the attending physician proposes

TNFs *like Humira Enbrel* and in line 254 the IMG resident makes the final treatment call as she

says *so let's just do the Enbrel*.  With these multiple turns the treatment decision is made for the

patient to start the medication Enbrel.  Patient acceptance, on the other hand, is provided rather

atypically though it appears to function nonetheless as agreement to the treatment advice.  The

attending physician's turn design in line 250-251 presupposes TNFs as the treatment option and

advances the conversation to medication administration, questioning the patient about where she

will do the injections[15].  This turn design requires an answer from the patient, which she provides

(*no I can do it myself*) and which suggests likely acceptance of the recommendation.  In lines

259-260 the patient shows signs of reconsideration as she poses a question about the effects of

Enbrel on her immune system.  The attending physician affirms that Enbrel can lower the

immune system and a brief discussion ensues about the patient's immunizations (not shown

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[15] Enbrel is a medication that is injected just under the skin by the patient or caregiver.

here). Thereafter, the patient asks *and that's subq right*[16] and with this medication administration question she returns discussion to the treatment plan thus signaling acceptance of the recommendation.

In comparison to other extracts shown thus far, this extract appears to demonstrate that IMG resident initiated treatment advice sequences are not only co-constructed but also require negotiation between the attending physician and IMG resident. In other words, treatment advice is posed as a possible option but to enact it requires support and ultimate assent from the supervising attending physician. We will see in the following section, in research question two, that the IMG resident from Extract 4.6 also gives treatment advice to the patient during the solo interaction. The treatment advice sequence during the solo interaction will demonstrate some uncertainty on the part of the IMG resident as the data reveals she relinquishes treatment decision-making authority to the attending physician. Thus, during these two phases, the solo and joint interactions, we see that though the IMG resident contributes to the unfolding of the treatment advice phase, she, in the end, relies on the ultimate authority of her attending physician to make the final treatment call.

As noted above, there is one other interaction in which the IMG resident initiates the treatment advice during the joint interaction. This interaction will be displayed in the following section (see "Multi-party talk" section). As will be demonstrated, the IMG resident also confers with his attending physician about the treatment advice. Though this interaction will show that less negotiation occurs between attending physician and IMG resident, as compared to Extract 4.6, in the end the attending physician makes the final treatment call. It is important to point out that due to the fact there are only two instances in this dataset in which the IMG resident initiates

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[16] Subq is an abbreviation for subcutaneous, which means under the skin.

treatment during the joint interaction, additional data is necessary to determine if this is a

common feature of IMG resident initiated advice or if these interactions are exceptional.

### *Patient initiated advice.*

In addition to the attending physician and IMG resident initiating treatment advice, the

patient can also initiate the treatment advice sequence.  This occurred four times in this dataset.

Three of the four times occurred during the solo interaction phase with the IMG resident.  One of

these interactions will be shown during my examination of research question two (see "Solicited

treatment advice" section).  In the three patient initiated advice sequences during the solo

interactions, the patients utilize an interrogative to open up the sequence.  In comparison,

however, in the example that will be shown here the patient makes a direct statement as regard

her treatment plan.  The extract shown below comes from the joint interaction phase during a

follow-up visit in the Rheumatology clinic.  The patient, a female, is diagnosed with Ankylosing

Spondylitis and takes the medications Meloxicam, Gabapentin, and Amatriptyline.  The patient

initiates the sequence with the following statement:

Extract 4.7 RHOI006 Ankylosing Spondylitis
322:   PAT:   =one of the rem- okay so you want me to go back on the Sulfasalazine
323:   ATT:   yeah you're getting
324:   FEL:   the other thing we were thinking is you were thinking about eh the
325:          Leflunomide $^O$last time$^O$
326:   ATT:   well we could use Leflunomide but she previously did well on
327:          Sulfasalazine no an she's mostly peripheral so knowing that I would
328:          probably go back to on it Sulfasalazine >to be honest with you< I mean
329:          you tolerated it well an overall you did pretty well on it
330:   PAT:                    [yeah                          [yeah uhm uh
331:   ATT:   Leflunomide is another medicine that works really well for this but if we
332:          know you did well on Sulfasalazine I'd probably (sway) towards that
333:          first=
334:   PAT:   =yeah uhm cuz you know me an meds I

Prior to this sequence the three interlocutors are discussing the patient's current

medications.  In the past the patient had been taking the medication Sulfasalazine but she had

been off it for a long time.  The attending physician seems to remember putting her back on

Sulfasalazine during the last visit but the IMG resident and patient both agree that was not the

case.  The discussion about the Sulfasalazine, and how the patient's condition improved or did

not improve while on it, continues until the patient says in line 322 after a false start *so you want*

*me to go back on the Sulfasalazine*.[17]  Based on how the prior discussion was progressing, the

patient appears to have concluded that the attending physician was going recommend she go

back on Sulfasalazine.  Therefore, with this statement she seizes his authority and takes the

words out of his mouth, so to speak.  To this statement the attending physician responds *yeah*

thus confirming her supposition.  The attending physician wants to continue but the IMG

resident interrupts with a reminder that the medication Leflunomide was previously under

consideration during the last visit.  The IMG resident does an interesting change in pronoun

usage from *we* to *you*, as if remembering mid-thought that it was indeed the attending physician

who recommended Leflunomide.  To complete the sequence, the attending physician spends the

remainder of talk providing justification for his preference for Sulfasalazine – *she previously did*

*well on Sulfasalazine* (lines 326-327); *she's mostly peripheral* (line 327); *you tolerated it well*

(line 329); *overall you did pretty well on it* (line 329).  Neither the patient nor the IMG resident

attempt to sway him away from this preference, consequently the patient will restart

Sulfasalazine.

    This extract demonstrates that it is possible for a patient to make a treatment

recommendation.  As displayed here, the patient uses a declarative and her own agency to

actualize the decision to restart Sulfasalazine.  The progression of the multi-party discussion

compelled her to draw her own conclusion and led her seize medical authority to verbalize the

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[17] It is possible to analyze this phrase as either a declarative statement or an interrogative. However due to the fact the patient does not use rising intonation at the end of the phrase I classify it as a declarative.

treatment recommendation on her own. Viewed within the medical domain, this patient initiated

treatment recommendation could be interpreted as an exemplar of patient-centeredness or as a

complete usurpation of physician medical authority. However, by analyzing the talk in action as

it unfolds also allows for a more measured interpretation demonstrating that the discussion

leading up to the patient's statement in line 322 created an opportunity for this next turn. In

other words, the attending physician's case for restarting Sulfasalazine was already in full motion;

as the conversational turns progressed it was only a matter of time that one of the participants

would bring the discussion to a close with a treatment recommendation. In this case, and as it

turns out, the recommendation came from the patient.

As will be demonstrated below (see "Solicited treatment advice" in research question two

section), other patients also initiate treatment advice. However, as previously noted, the patients

utilize interrogatives seeking the physician's advice as to how to proceed with the treatment plan.

In this way and as these examples will demonstrate, the medical authority remains with the

physician to give their treatment advice. Consequently, it remains possible that the way in which

the patient initiated advice in Extract 4.7 may prove to be anomalous or a unique feature not

frequently found during the treatment advice phase. Additional naturally occurring data from the

medical encounter, specifically the treatment advice phase, is required to further explore this

particular phenomenon.

**Multi-party talk**

As previously discussed in the section above, the phases of solo interaction and joint

interaction, as I called them, uniquely defined this dataset. As demonstrated, this uncommon

structural feature (uncommon in this area of research but not uncommon within medical practice)

played a role in how treatment advice was actualized. An additional feature found in these data

that will be explored here is the concept of multi-party talk. By multi-party talk I simply mean a conversation that occurs between more than two interlocutors. Most prior research using naturally occurring talk as the primary data source mainly examines two-party talk in everyday conversations and institutional interactions. Multi-party talk, on the other hand, remains understudied across various contexts (McKinlay & McVittie, 2006; Mondada, 2013; see Tsai, 2005 for an example in the medical context).

When I started this research and attempted to envision the unfolding of the medical encounter interactions, the concept of multi-party talk did not enter into my imagination. I was slightly able to imagine interactions occurring between the patient and two physicians, as has been the focus thus far, but these were even difficult for me to envision how they would play out. Consequently, much to my surprise, from the second interaction I observed and recorded it was frequently the case that additional participants would participate in the medical encounter. More often than not, the additional participant was an individual who accompanied the patient to the medical encounter (in other words, the additional participant was not, for instance, the staff nurse at the clinic). Additionally, the individual remained in the examination room with the patient, and more often than not, participated in the medical encounter discourse. In this way, the concept of multi-party was truly enacted many times during these medical encounters as IMG resident, attending physician, patient, and the patient's advocate participated in the interactions. The patient advocate was usually the husband or wife of the patient. On other occasions it was the father, mother, daughter, or nurse. On two occasions a medical student accompanied the IMG resident during the medical encounter and in both instances he contributed to the interactions by asking questions of the patient and presenting the patient to the IMG resident. Moreover, in some instances (i.e., interactions NEOK001 and NESG002) the patient advocate

became the voice of the patient as he or she spoke on behalf of the patient for various reasons. In

all, 11 of 28 transcribed interactions are these multi-party interactions as I describe here.

In this section I will present extracts from two different interactions demonstrating multi-

party talk in action. The extracts will demonstrate how these additional parties (e.g., husband,

wife, nurse) affect the unfolding of the interaction as they contribute to key moments during the

treatment advice phase. The first extract comes from a follow-up visit at the Rheumatology

clinic. The medical encounter occurs with a patient diagnosed with lupus and the patient's

husband. The patient had been prescribed the medication Dapsone, used to reduce itching and

redness of the skin caused by the lupus. Here I will display two extracts – one extract from the

solo interaction between IMG resident, patient, and patient's husband and the second extract

from the joint interaction. The first extract is presented below. The IMG resident had just

completed a physical examination of the patient's stomach (she complained of recent stomach

problems and bloating) when the patient's husband opens up the treatment advice sequence with

the following:

Extract 4.8 RHOI008 Lupus (Solo interaction)
180:   PAT HUS:   so we're we're gonna get a refill if you want her ta stay on it
181:   FEL:       okay so let me talk to the boss here uh see what he thinks cuz I'm
182:              not so bottom line you didn't see an improvement from the
183:              medicine
184:   PAT:       not not in my skin

In the second extract from this interaction occurring during the joint interaction phase, the

patient's husband again directly participates in the treatment advice sequence. Immediately prior

to Extract 4.9, discussion between all four individuals centered on the redness of the patient's

skin and whether she was responding to the Dapsone. The patient's husband brings this

discussion to a close as he says:

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Extract 4.9 RHOI008 Lupus (Joint interaction)
401:    PAT HUS:    you gonna bump her up to two two a day whatdya think
402:    ATT:        two a day yeah
403:    PAT HUS:    two a day
404:    ATT:        an it doesn't
405:    PAT HUS:    bump her to two pills a day
406:    ATT:        so we're going go up to fifty right
407:    PAT:        oh my god

To add to the previous section focused on which participant initiates the treatment advice sequence, in both Extract 4.8 and Extract 4.9 we see that it is the patient's husband who opens the sequence. In the previous section we observed that the attending physician, IMG resident, or patient, could initiate the treatment advice sequence. Here, a fourth possibility is presented with the patient's advocate, in this case the patient's husband, initiating the sequence with *so we're we're gonna get a refill if you want her ta stay on it* (line 180) during the solo interaction and *you gonna bump her up to two two a day whatdya think* (line 401) in the joint interaction phase. With each initiation the patient's husband uses his turn to advance the discussion to the treatment recommendation. During the solo interaction with the IMG resident the patient's husband uses a statement about getting refills (for the Dapsone) to change topic, open up the treatment advice sequence, and compel the IMG resident to deliver his treatment advice, to which he takes an ambivalent stance. In comparison, in the joint interaction phase the patient's husband initiates the treatment advice sequence and correspondingly makes a treatment recommendation to increase the Dapsone dosage. With this dosage increase recommendation, the patient's husband appropriates medical authority but the question format and tag question *whatdya think* mitigates the recommendation's force and directness by appealing to the expertise of the two physicians.

In both Extract 4.8 and Extract 4.9 we also see how all four participants engage in and co-construct the giving and receiving of the treatment advice. During the solo interaction, the patient's husband initiates the advice giving sequence, the IMG resident provides a response

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indexing his role as physician to offer his treatment recommendation, and the patient provides a response which is an unfavorable assessment of how the medication is working on her skin. In the joint interaction, three of the four participants co-construct the treatment advice sequence; the IMG resident provides no turn during this section of talk. Similar to the solo interaction, the patient's husband commences the treatment advice. In lines 402 through 406 the patient's husband and attending physician volley turns to confirm the dosage increase. It is not until line 407 that the patient joins in and expresses her displeasure with the decision to increase the Dapsone dosage just made on her behalf. The patient's unfavorable assessment is not taken up by any of the participants and instead the attending physician changes topic in the next turn to the patient's recent lab values. So while Extract 4.9 demonstrates the co-constructed nature of the giving and receiving of treatment advice through multi-party talk, it also appears to serve as an example of how some participant's voice can get "lost" or silenced as a conversation continues to unfold and progress turn by turn.

Turning to the next multi-party talk example, it also occurs during a Rheumatology clinic visit. The interaction takes place with a patient who is following up on her rheumatoid arthritis condition. A nurse accompanies the patient to the visit and remains in the examination room throughout the visit. It was clear from my observation and the audio of their conversation during other parts of the medical encounter that the patient and nurse had an established relationship; they talked openly and appeared comfortable with one another. Similar to the interaction displayed above, I will present extracts from both the solo and joint interaction phases to demonstrate how multi-party talk is used to co-construct the treatment advice sequence. The IMG resident initiates the treatment advice sequence in the solo interaction by asking the patient what she would like to do with her current treatment.

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Extract 4.10 RHOI011 Rheumatoid arthritis (Solo interaction)

| | | |
|---|---|---|
| 114: | FEL: | okay so okay so (1.0) shall we change something or not really |
| 115: | PAT: | huh? |
| 116: | FEL: | do you feel like we need to change something or not really |
| 117: | PAT: | hum |
| 118: | NUR: | are you happy with what you're taking now do you feel that= |
| 119: | PAT: | =yeah I'm fine ᴼI'm fine with itᴼ |
| 120: | NUR: | do you feel like he needs to increase it er do you wanna try an decrease it |
| 121: | | how do you feel? |
| 122: | PAT: | I'd increase a little bit |
| 123: | NUR: | increase it a little bit? |
| 124: | PAT: | maybe see maybe one more tablet maybe I dunno |
| 125: | FEL: | because of the joint pain= |
| 126: | PAT: | =yeah joint yeah joints yeah |
| 127: | FEL: | okay okay so let's call the boss |
| 128: | PAT: | okay |
| 129: | NUR: | boss man ((PAT laughs)) |
| 130: | FEL: | and tell him (XX) (basically) we need to increase a little bit and we'll go |
| 131: | | from there |
| 132: | PAT: | okay |

During this solo interaction, the IMG resident chooses to solicit the patient's input about her treatment plan going forward (line 114). After two unsuccessful attempts, requiring clarification checks from the patient, the nurse joins the conversation. Starting on line 118 the nurse intervenes attempting to solicit an answer from the patient. Her turns (line 118 and lines 120-121) rephrase the IMG resident's original solicitations. After seven turns between the IMG resident, patient, and nurse, the patient at last answers – *I'd increase a little bit*.[18] Thereafter, confirmation checks are issued to reinforce the patient's decision: the nurse issues one in line 123 to confirm the patient's desire and in line 125 the IMG resident seeks patient input to rationalize her decision to increase the dosage of Methotrexate. Both the solo interaction phase and the treatment advice sequence comes to a close when the IMG resident says *okay okay so let's call the boss* but not before the nurse takes one more opportunity to provide input when she says *boss man* in a loud, playact-like voice to which the patient laughs.

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[18] The medication the patient would like to increase a little bit is Methotrexate.

The nurse also contributes to the treatment advice sequence during the joint interaction phase but her contributions provide different functions as will be discussed below. In the discussion prior to Extract 4.11 shown below, the attending physician was asking about the patient's medication, thus prompting the IMG resident to make the following move:

Extract 4.11 RHOI011 Rheumatoid arthritis (Joint interaction)
```
222:   FEL:   so she was asking when we reached to the question like does she feel this
223:          is okay or not
224:   PAT:                                                        [maybe
225:          (one tablet)
226:   FEL:   was asking can she have one more tablet of Methotrexate
227:   NUR:   cuz her hands were startin to hurt she said a little bit more than normal
228:   ATT:                                    [are they? so more morning stiffness?
229:   PAT:   yeah morning stiffness
230:   ATT:   okay ah yeah I mean you we'll go as high as eight sometimes in males er
231:          bigger patients I'll push it even ta ten but certainly we have room ta go up
232:          if you think it's it's necessary now the thing that's always important ta try
233:          an sort out is remember that people that have long standing rheumatoid
234:          arthritis always develop some degree of secondary osteoarthritis
235:   PAT:                                    [right
(Discussion about symptoms and how Methotrexate treats them; off-topic discussion about
mutual acquaintance)
282:   ATT:   anyway so let's inch it up ta seven you tolerate the Methotrexate
283:   PAT:   yeah
```

In this joint interaction phase we see that the IMG resident in line 222 initiates the move into the treatment advice sequence. As previously mentioned, the dataset contained two instances of IMG resident initiated treatment advice. The first example was displayed in the "IMG resident initiated advice" section above and this is the second example I wish to show. In lines 222-226 the IMG resident's and patient's turns serve to summarize the treatment proposal reached during the solo interaction phase. In the following turn (line 227) the nurse chimes in and issues a justification for the proposed increase in medication dosage to which the attending physician chimes in to seek patient confirmation. Thereafter, the attending physician spends time providing education about dosage and health outcomes related to the use of Methotrexate.

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Following line 235 the four participants work jointly to account for the patient's symptoms and how Methotrexate works to treat them. Next, the nurse abruptly changes topic; she says, *one of our doctors told me to tell you hi because he said* (in line 265 but not displayed in Extract 4.11). This statement is directed at the attending physician and over the next several turns he and the nurse discuss this mutual acquaintance. In line 282, and in an abrupt shift out of a personal frame and back into the medical frame, the attending physician returns to the topic of the patient's treatment plan. With this treatment recommendation (in line 282) and the patient's acceptance (line 283) a mutual decision is reached to increase her Methotrexate dosage.

Taken together, the solo and joint interactions demonstrate how the nurse's contributions provided both forward momentum and momentary halts to the treatment advice sequences. In both interactions her turns worked to influence the medical domain by providing rationale to the treatment proposal and intervening when it appeared treatment negotiation had stalled. In addition to her contributions to the medical domain, the nurse also, on several occasions, steered the conversation to the personal domain (additional conversation topics include: IMG resident's country of origin, mutual acquaintance, and patient's animals). These diversions into the non-medical domain serve to lighten the conversation and build relations, highlighting the humanistic side of medicine (see further discussion in research question four).

Yet despite the nurse's contributions, she does not participate in a vacuum. The nurse's participation, coupled with the participation of the patient, IMG resident, and attending physician, together unfolded the medical encounter interaction. The multi-party talk co-constructed by the four participants worked to negotiate and jointly construct the treatment recommendation to increase Methotrexate.

**Conclusion**

To summarize this section of the paper, the aim of research question one was to examine the overall structure and organization of the treatment advice phase. This study adds to the body of research on the treatment advice phase in three key areas: a) the segmentation of the medical encounter into the solo interaction and joint interaction phases, as I termed them, as a result of the IMG resident and attending physician participation in the medical encounter; b) the initiation of treatment advice and; c) multi-party talk.

In this section I presented the two distinct phases that manifest as a result of a supervised medical encounter. The first phase is the solo interaction, occurring between IMG resident and patient. During solo interactions, these data demonstrated that the giving of treatment advice is optional, as only 57% of the time the IMG resident delivered a treatment recommendation to the patient. When IMG residents do offer treatment recommendations, the extracts demonstrated that IMG residents utilize different delivery formats to give advice: they offer treatment recommendations or they pursue patient input regarding the future course of treatment.

The joint interaction phase occurs subsequent to the solo interaction phase and occurs between attending physician, IMG resident, and patient. The data revealed that in comparison to the solo interaction phase and when advice was required, the delivery of treatment advice was not optional during the joint interaction phase. Given these two separate phases it is possible then that the patient will receive two treatment recommendations, one recommendation from the IMG resident and another from the attending physician. The data showed that in some instances the IMG resident's and attending physician's recommendations aligned and in other instances there was slight deviation in the two recommendations. Moreover, the treatment advice delivery

formats deviated with the IMG residents utilizing more indirect treatment giving strategies as compared to their attending physicians.

Importantly, the interactions that occurred in both the solo and joint interaction phases demonstrated the co-constructed nature of treatment advice sequences. Through each conversational turn, both patients and physicians jointly constructed the sequences. The data revealed that the co-construction process sometimes occurred directly and over a small number of turns and in other instances reaching consensus required protracted negotiation.

In addition to the solo and joint interaction phases, I also explored the initiation of the treatment advice, how it materialized, and by whom. These data added to the extant body of treatment advice literature by exploring which topics or actions preceded the advice giving sequence. The data revealed that while multiple topics of conversation directly preceded the treatment advice phase, the most common were the patient's medical condition, diagnosis, current medication(s), or the attending physician was completing the physical exam. In this section I demonstrated that the attending physician, IMG resident, or patient could initiate treatment advice. In addition, in the "Multi-party talk" section we also saw the patient's husband initiating the treatment advice sequence. The attending physician initiated the sequence most frequently (91%). Furthermore, while the IMG resident and patient also initiated the treatment advice sequence, additional research is required in this area to substantiate my initial findings.

The final feature that characterized the structure and organization of these data and thus required examination was multi-party talk. In addition to the multi-party talk that took place in the joint interaction phase between patient, IMG resident, and attending physician, there were also several interactions in which four individuals were present in the medical encounter. This transpired as a result of another individual (e.g., spouse, parent, nurse) accompanying the patient.

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I examined in detail two examples in which a patient's husband and a nurse directly contributed to the unfolding of the treatment advice sequence. The examples demonstrated how these ancillary participants contributed to the interactions by initiating the treatment advice sequence, answering questions, compelling the patient to answer questions, providing justifications, and developing interpersonal relations with the physicians. As such, these ancillary participants played a unique role serving as the patient's advocate, speaking on behalf of the patient, and also expanding the interaction into the personal and humanistic domain.

Overall, the purpose of research question one was to provide a high level view of the organizational and structural features of the treatment advice phase in this dataset. In this section I attempted to describe the two distinct phases of the treatment advice phase, explore who initiated treatment advice and during which phases, and examine how multiple participants jointly constructed, negotiated, and ultimately decided on a treatment plan for the patient. As I move into the next section to explore research question two, I will provide a more detailed examination of the treatment advice phase, specifically exploring how the IMG residents give treatment recommendations. The level of analysis will be more granular as the discourse and linguistic features of the IMG residents' treatment advice are explored in greater detail.

**Research Question Two**

In the treatment advice phase, what directive strategies do IMG residents use?

To address this research question I will specifically focus on the treatment advice given by the IMG residents. As described in the section above, either the IMG resident, attending physician, or both can recommend treatment to the patient. However, due to the fact the main participants in the study are the IMG residents, this section examines the ways in which the IMG residents advise patients of treatment options.

As discussed in Chapter two and to review here, Searle (1976) defined directives as a type of speech act that make "attempts of varying degrees…by the speaker to get the hearer to do something" (p. 11). Some verbs associated with directives are *ask*, *order*, *command,* and also *invite*, *permit*, and *advise*. The directive under examination in this study is advising or the giving of advice. In comparison to other directive speech acts, advising or *advisories*, using Bach and Harnish's (1979) terminology, consider the action being performed from the hearer's perspective. In other words, directives can be considered *advisories* when the speaker's actions benefit the hearer or have the hearer's best interests in mind (Bach & Harnish, 1979; Tsui,1994). Providing a specific definition of advice, Locher and Limberg (2012) point out that "advice exchanges constitute a communicative act that is subject to negotiation between speaker (or writer) and the addressee (or reader)" (p. 1). In this definition they too emphasize the co-constructed and discursive nature of advice by mentioning both the speaker and hearer. In addition, Locher and Limberg extend the definition of advice by highlighting the negotiable attribute of advice giving and receiving.

Advising or the giving of treatment during the medical encounter brings into sharp focus this sub-category of directives. It can be argued that the critical moment of the medical encounter is the advice the physician gives to the patient on the best course of action to heal, cure, or improve their health condition or outcome. As such, the data presented here will reveal the ways the IMG residents advise their patients on the best course of treatment to help improve their health conditions.

At a most basic level, the interaction data reveals that during some of the medical encounters the IMG residents give treatment advice to their patients and in other medical encounters the IMG residents do not give treatment advice to their patients. As discussed in the

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previous section, in the 28 transcribed interactions, IMG residents give treatment advice in 16 of the medical encounters or 57% of the time. Contrarily, in 12 of the 28 medical encounters or in 43% of them, the IMG residents do not give treatment advice to their patients.

In this section I will examine the directive strategies used by the IMG residents to give treatment to patients. However, before examining the different advice giving strategies, I will discuss briefly the medical encounter interactions that involved the IMG residents giving no treatment advice to the patient.

As mentioned above, no treatment advice is given in 12 of 28 medical encounters. In these instances, there appear to be persuasive reasons and explanation as to why no treatment advice is given. For instance, in the dataset there are medical encounters that involve new patients. In some of these new patient medical encounters no treatment is given. Instead during the medical encounter, various diagnostic tests, for example x-rays, MRIs or lab work, are ordered to provide additional data about patients' conditions. In other medical encounters, the interaction with the patient reveals that their condition does not warrant a change to the present course of treatment. In these examples, of which there are two, the IMG resident does not verbalize a treatment recommendation. In contrast, however, the IMG resident's attending physician does indicate to the patient that their treatment plan would not be changing. For example, Extract 4.12 provides an example in which the patient recently started taking the medication Remicade to treat rheumatoid arthritis and was showing improvement. After asking the patient if she had any questions about taking the Remicade, the attending physician says:

Extract 4.12 RHCG002 Rheum arthritis
194    ATT:   (okay) we'll stay on the course=
195    PAT:   =yeah

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In this brief two turn exchange, the attending physician indicates to the patient that she should stay the course with taking Remicade as prescribed.  Though brief and to the point, the attending physician completes the treatment advice phase and provides necessary, reassuring information to the patient to maintain the current treatment plan.

Moving on to the primary analysis to address the research question – in the treatment advice phase, what directive strategies do IMG residents use – I will explore the multiple strategies IMG residents use to give treatment advice.  In this section I will examine the specific directive forms IMG residents utilize.  As discussed in the sections that follow, the directive form most frequently utilized is the declarative.  The data will show that declaratives for the most part are formulated using external and internal mitigation to lessen the force of treatment advice.  In addition, the declarative forms used to give treatment advice occur either spontaneously or they occur following a solicitation seeking input about the treatment plan.  Finally, strategies used to give future treatment advice will also be discussed.

**Treatment advice declaratives.**

Data analysis revealed that IMG residents give treatment advice in a variety of ways.  However, a consistent feature found across the data containing IMG resident treatment giving sequences is that declaratives are used to give treatment advice.  As a speech act, directives can be formed using a range of structures:  imperatives, interrogatives, and declaratives (Ervin-Tripp, 1976; Holmes, 1983; Vine, 2004).  Additionally, as regard the specific speech act of advisories or advice, Locher (2006) demonstrated that advice could also be given using the syntactic forms of declaratives, imperatives, and interrogatives (p. 260).  Locher's data showed that declaratives were used to give advice 52% of the time.  In these data however only one syntactic form, the declarative, is utilized to provide patients with treatment advice.  These declaratives were formed

in different ways with varied strategies, but what remains clear is that IMG residents overwhelmingly used the declarative form when it came time in the medical encounter to give treatment advice to their patients.

It is certainly possible that the IMG residents could have used all three directive structures to formulate their treatment recommendations. Imperatives could have been used to more directly convince or command patients to continue taking their medication as prescribed or to modify dosage or frequency. Only one imperative is found in these treatment giving data and will be shown below. Interrogatives are used during the treatment advice sequence but they are not used explicitly to give treatment advice. As noted previously and as will be discussed further below, the interrogative structure is used in some instances to enter into the treatment advice sequence to solicit advice or seek input or information. However, it was without surprise that treatment giving directives were not formulated as interrogatives given their questioning function and common usage for making requests or seeking information (Ervin-Tripp, 1976; Holmes, 1983). As will be presented in the examples below, the subject + verb structure that defines declaratives is the structure IMG residents turn to when providing patients with treatment advice.

### *Spontaneous treatment advice.*

Turning to the data, the first example comes from a rather straightforward exchange with a patient who came to the Neurology clinic to seek a secondary opinion on her recent multiple sclerosis diagnosis. The IMG resident states:

Extract 4.13 NEJG002 Multiple sclerosis
121:  RES:  obviously here we have a little situation because our MS specialist is Dr.
             Stinton
122:  PAT:  right
123:  (0.5)
124:  RES:  eh that doesn't mean we can't treat you here >or anything like that< but
             he's the MS specialist
125:  PAT:                                                            [uhm uh

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126:   RES:   and he has multiple trials as well for patients like this
127:   PAT:   uhm uh
128:   RES:   **uh we're gonna continue with the Rebif probably? for now**…(topic change)
129:   PAT:   uhm uh

Embedded in this stretch of talk about the multiple sclerosis (MS) specialist on staff is a short two-turn sequence in which the IMG resident gives the patient his first indication and opinion about his treatment recommendation. In the treatment advice turn the IMG resident starts with a hesitation *uh* and proceeds directly into the declarative *we're gonna continue with the Rebif*. Here, the IMG resident's treatment advice is formed using the pronoun *we* followed by *gonna*, which is the reduced form of the semi-modal *be going to* and is commonly found in spoken language (Biber, Conrad, & Leech, 2002). The verb *continue* is used suggesting that the Rebif medication, which the patient is currently taking, will not change. The IMG resident hedges his advice through the use of *probably* and also through his use of rising intonation. This hedged advice indicates that this is his recommendation as the resident and he will still need to discuss the recommendation with his supervising attending physician. He ends the treatment advice with the temporal marker *for now*, suggesting that the medication could change in the future.

This example serves to illustrate some of the epistemic devices IMG residents use to mitigate or make more indirect their treatment advice to patients. In this example we see the use of hesitation, hedges, intonation, and a modalized verb form to mitigate the directive. As additional examples will demonstrate in the examples that follow, these types of mitigation strategies are a common feature of IMG residents' treatment recommendations and characterize the ways in which the IMG resident indirectly offer treatment advice to their patients.

Additionally, this example demonstrates the, at times, spontaneous nature of treatment advice giving. In this example, the IMG resident makes a treatment recommendation while discussing the topic of the MS specialist on staff. In other words, treatment advice is embedded

in the discussion of another topic thus making the initiation of treatment advice spontaneous in

nature.  In this example and in others presented in this section, spontaneous versus solicited

treatment recommendations will be examined[19].

Looking at another treatment advice sequence with a different IMG resident, a Neurology

resident, this example further demonstrates the spontaneous nature of treatment advice.  As seen

in the first example where the treatment advice was embedded in a discussion about an MS

specialist, this treatment advice example is embedded in talk about one of the medications the

patient, who is a new patient, is currently taking.

Extract 4.14 NEOK004 No diagnosis
| | | |
|---|---|---|
| 77: | RES: | mhm mm (13.0) okay so you're taking Amlodipine aspirin hypertensive |
| 78: | | medication you're taking are you not taking Neurontin? |
| 79: | PAT: | uh? |
| 80: | RES: | Neurontin Gabapentin |
| 81: | PAT: | I'm takin that |
| 82: | RES: | yeah so this (XX) |
| 83: | PAT: | Gabapentin |
| 84: | RES: | it doesn't work |
| 85: | PAT: | it work a little bit but sometime it don't work |
| 86: | RES: | **okay maybe we could amp up a little bit more** are you taking one |
| | | hundred milligram? |
| 87: | PAT: | [huh? |
| 88: | PAT: | of what? |
| 89: | RES: | Gabapentin |

In this example the IMG resident's treatment advice formulation starts with the discourse marker

*okay* and is followed by a hedge – *maybe*.  In the declarative that follows the IMG resident uses

the pronoun *we* indicating the collaborative nature of this decision followed by the verb phrase

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[19] It is fair to say that in the very act of attending a medical visit, patients are seeking solicited advice from their physicians.  Various researchers have examined solicited and unsolicited (spontaneous) advice-giving and advice-seeking sequences primarily through the notion of power and the concomitant variables of expertise, authority, and competence (DeCapua & Huber,1995; Heritage & Sefi, 1992; Vine 2004).  In this section I use these terms, solicited and unsolicited, in a different manner than these previous researchers.  I take as a starting point that all physician-patient interactions are examples of solicited advice.  Here, unsolicited (I use the term spontaneous) treatment advice refers to instances of advice that are embedded in stretches of discourse that are unrelated or only partially related to treatment.  Solicited treatment advice refers to instances where the treatment-giving phase is initiated or opened up through interrogatives seeking patient or physician input about treatment.

*could amp up*. The verb phrase is constructed using a modalized verb form indicating possibility followed by the colloquial phrasal verb *amp up*. It is clear that the IMG resident is aware that *to amp up* means to increase, in this case increase the patient's medication dosage. The medication she is recommending to be amped up goes unnamed but based on the surrounding talk it seems clear she is referring to the Gabapentin the patient is currently taking. Furthermore, I would argue that this example demonstrates advanced L2 command through the indirect construction of the formulation, the use of the informal phrasal verb *amp up*, and the use of hedges.

Similar to Extract 4.13, this example demonstrates the spontaneous nature of treatment advice giving. In both examples, the IMG residents find opportunity while exploring various topics of discussion with their patient (in Extract 4.13 an MS specialist, in Extract 4.14 current medication) to interject their treatment recommendation. In Extract 4.14 the IMG resident uses the Gabapentin discussion to render an opinion that an increase in dosage may serve as treatment advice. Toward the end of her solo interaction with the patient, the IMG resident concludes:

119:   RES:   …okay so I'm gonna talk to our boss and then we're gonna discuss what
120:            we're gonna do **we could run some test or we could give you a little bit**
121:            **more medications okay**? (0.5) have you seen the neurologist before or is
122:            this the first time
123:   PAT:   uhm uh

This turn starting on line 119 serves to conclude her interaction with the patient, inform him of her next steps, and summarize the possible treatment recommendations. In this way, the IMG resident's turn works holistically to wrap-up her interaction with the patient. Examining the treatment recommended here, the IMG resident modified it to include the possibility that tests could be run instead of or in addition to increasing the patient's medication. In addition to this recommendation using a vague reference to *some test*, she maintains a version of her original advice in line 86 but modifies it slightly to make an additional vague reference to *more*

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*medications*.  Using this vague reference it thus becomes unclear whether the IMG resident is still referring to the Gabapentin the patient is currently taking or is she suggesting an additional medication, perhaps adding a medication to his regimen.  Vagueness, coupled with the use of inclusive pronoun usage, modalized verb forms and a tag question, are specific indirect advice giving strategies used in Extract 4.14.  Moreover, this example also serve to demonstrate more generally how IMG residents use a range of linguistic and discourse devices which serve to attenuate their authoritative force and attend to the face needs of their patients during the medical visit.

The previous examples have demonstrated how treatment can be given concisely and over a limited number of turns.  The following example is more complex and continues over several turns.  In the analysis of research question one this interaction was examined to demonstrate how the IMG resident initiated the treatment advice sequence during the joint interaction between patient, IMG resident, and attending physician.  To review, the extract comes from a follow-up visit with a patient at the Rheumatology clinic.  The patient is diagnosed with psoriatic arthritis and has experienced increased arthritic symptoms since her last visit.  She stopped taking the medication Arava recently because of concerns of the medication causing high blood pressure in the patient.  After discussing with the patient how she responded to the Arava prior to discontinuing its use, the IMG resident states:

Extract 4.15 RHCG006 Psoriatic arthritis
93:     FEL:    okay (4.0) **let's start you in on something** u:hm (PAT chuckles) how's
94:             your blood pressure now that you're off the Arava is it better?
(Several turns devoted to the discussion of the patient's blood pressure)
112:    FEL:    …let's see I mean (1.0) **maybe Dr. uh Zhen will wanna I mean we we**
113:            **probably should escalate therapy anyways cuz air it wasn't controlled**
114:            **anyways** (X) Arava completely
115:    PAT:                                                    [I underst- yes
116:    FEL:    uhm but we'll see with him what he thinks **if we should restart you on**
117:            **the Arava in addition to starting another agent**

118:    PAT:    <sup>o</sup>okay<sup>o</sup>

This example illustrates how the giving of treatment occurs and reoccurs and how it transpires over several turns. In this example the IMG resident initiates treatment advice in three separate turns (line 93, lines 112-114, lines 116-117). On line 93 the IMG residents makes known she thinks some sort of treatment needs to be initiated but temporarily shifts topic to the patient's blood pressure. This first turn takes an imperative form (the only imperative used to give treatment advice) and uses the special imperative clause *let's* + imperative. Using this form softens the imperative because the first person plural pronoun *us* is included within the form. In this way, *let's* expresses a suggestion between the speaker and hearer (Biber, et al., 2002; Vine, 2004). In this example the IMG resident uses *let's* followed by the verb *start* to indicate to the patient that she wants to start treatment on her. The IMG resident uses a vague medication reference – *something*, which may indicate her uncertainty about what medication to prescribe or her unwillingness at this point in the interaction to commit to a specific course of treatment.

After a brief blood pressure discussion, the IMG resident returns to the topic of treatment. In line 112 the IMG resident starts out hesitantly with fillers and a one second pause followed by the hedge *maybe* as she moves into the treatment advice declarative. The declarative takes the form: *maybe Dr. uh Zhen will wanna I mean we we probably should escalate therapy anyways….* The IMG resident starts out by stating what she thinks her attending physician, Dr. Zhen, will want to do. By naming him directly it would appear she is relinquishing authority and decision making to him. However, what Dr. Zhen will want to do goes unnamed as her thought process is not rendered into linguistic form. Thereafter the IMG resident shifts decision making back to the collective *we* and she says *we we probably should escalate therapy anyways*. With

this noun to pronoun modification, authority attribution shifts from Dr. Zhen to a jointly

constructed membership between the attending physician, IMG resident, and patient.

Turning to the declarative's verb construction, in this turn the IMG resident utilizes the

modal *should* to express obligation followed by the verb *escalate* to indicate an increase to the

patient's current medication regimen.  Again, the specific medication the IMG resident is

thinking of is not named; instead the vague term *therapy* is used.  However, this time the IMG

resident provides a justification for her declared treatment advice – *cuz air it wasn't controlled*

*anyways*, likely to mean that the patient's psoriatic arthritis was not under control while taking

the Arava medication.

In turn 116 the IMG residents makes the third and final treatment advice statement.  In

this turn she reattributes some authority back to Dr. Zhen (*we'll see with him what he thinks*) and

she modifies the treatment recommendation (*if we should restart you on the Arava in addition to*

*starting another agent*).  It seems clear that though the IMG resident recognizes the treatment

decision as a jointly constructed one, in this case she appears to illustrate her willingness to rely

on her attending physician to make the final medication decision.  In this final turn the IMG

resident's treatment recommendation has become more specific with the naming of *Arava* and

*another agent*.[20]  Yet it appears she wants to clear this treatment recommendation with her

attending physician, thus yielding final authority to him.  This example then illustrates the

possible complex nature of the treatment advice phase.  As shown here, advice giving can occur

over multiple turns.  Additionally, the forms used to give treatment may vary although they still

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[20] Note how the IMG resident has moved from less to greater specificity in her use of medication terminology as the turns develop in this interaction.  The term *something* is used in line 93.  This term is replaced with *therapy* in line 113 and *therapy* is replaced with *Arava* and *another agent* in line 117.  Koenig (2008) refers to this medication naming convention as the "gradient scale of specificity" (p. 143).  In his research he demonstrated, as we see here in this Extract 4.15, that physicians move up and down the "gradient scale of specificity" to refer to medications and reformulate treatment recommendations (p. 177).

are formulated using linguistic and discourse devices that mitigate directness. Finally, the

vacillation of noun and pronoun usage in this example seems to demonstrate some uncertainty on

the part of the IMG resident to commit to a firm treatment recommendation. Though she finally

names a specific medication Arava (and *another agent*) she still cedes the final treatment

decision to her attending physician.

On some occasions physicians have to verbalize to patients that there is no need for

treatment. There is one instance of this type of occurrence in these data. Stivers (2005a) calls

this recommendations *against* treatment (p. 953). The example comes from a follow-up visit to

the Neurology clinic where the patient presents symptoms for a migraine headache. After

numerous probing questions to the patient, a physical examination, and a review of two MRI

images, the IMG resident concludes that the patient does not require any treatment for her

migraine headaches.

Extract 4.16 NESG001 Migraine headache
50:    RES:    **uhm I don't think you need any treatment for this** uh the fact that it's
51:            getting better in a few days it may go away completely uh if you want you
52:            can take a Tylenol or something uhm just as needed if you get a real bad
53:            headaches an >remind me< before this you did not have headaches right?
54:            (1.0) like you were not getting headache constantly like you did not have a
55:            diagnosis of migraine or anything so
56:    PAT:                        uhm uh
57:    RES:    probably this is what caused you to have headaches for a few days or few
58:            months an now it's getting better uh **I don't think you need to be on any**
59:            **treatment fur this**
60:    PAT:    was it do you know like uh I know they said somethin like it couldha been
61:            uh I was on birth control? you know that like was the cause of that

In comparison to the other extracts examined thus far, Extract 4.16 is one example that

demonstrates the use of more direct strategies to upgrade the force his treatment recommendation

to the patient. It is possible this direct strategy is used because no treatment is needed. However,

due to the fact there is only one example in the dataset no definitive conclusions can be drawn.

The IMG resident uses two declaratives phrased nearly in the same way to tell the patient

he does not recommend any treatment for her headaches.  He uses a negatively constructed

epistemic *I don't think* to indicate his belief that she does not need treatment.  Treatment for what

goes unnamed in his use of the vague reference *for this*.  It seems clear, however, based on the

previous talk that he is referring to her chief complaint and reason for the visit, namely her

migraine headaches.  In the construction of the treatment recommendation, the IMG resident

does not use the collaborative *we* pronoun as seen in previous examples but rather uses *I* and *you*

to explicitly state the agents of the action.  In doing so, he upgrades the force of his advice

statement by taking personal responsibility for the recommendation and conveying it directly to

the patient.[21]  The IMG resident reiterates his no-treatment recommendation beginning in line 58

(*I don't think you need to be on any treatment fur this*) and, as stated above, repeats it using a

nearly identical syntactic structure as compared to line 50 *(I don't think you need any treatment*

*for this)*.  Blum-Kulka et al. (1989) note that repetition may be used as a device to upgrade the

force of a directive (p. 286).  Thus, this use of repetition to state and restate his treatment advice

clearly calls the patient's attention to the IMG resident's recommendation.  In this way, it

intensifies the need for the patient to respond to it.  It may also be the case that the reason the

IMG resident has to repeat his treatment advice in line 58 is due to the fact the patient does not

respond initially to it.

There are some times when, after the question-answer session with the patient is over and

the physical examination is completed, that a future course of treatment is unclear.  Extract 4.17

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[21] It is interesting to note that this is one of only two medical encounter interactions in the data in which the attending physician does not join the IMG resident in the examination of the patient.  This extra contextual information about this particular medical encounter provides details that aid in my analysis and interpretation.  It may be only coincidence that the IMG resident structured his treatment advice in a more direct way or it may also be possible that he knew ahead of time his supervising attending physician would not be joining the encounter thus influencing his pronoun choices.

below is from a follow-up visit in the Rheumatology clinic with a patient diagnosed with lupus

and her husband (this extract was also shown in the "Multi-party talk" section in research

question one).  The patient was taking Dapsone, a medication prescribed to help itching and

redness on various parts of her body caused by the lupus.  The patient verbalizes her

ambivalence toward Dapsone and whether it is helping her red, itchy skin. The IMG resident

expresses no opinion.  After completing a physical examination of the patient's stomach (she

expressed she was recently having stomach problems and bloating), the conversation returns to

the topic of her medication.

Extract 4.17 RHOI008 Lupus
| 180: | PAT HUS: | so we're we're gonna get a refill if you want her ta stay on it |
| 181: | FEL: | okay so let me talk to the boss here uh see what he thinks cuz **I'm** |
| 182: | | **not so bottom line you didn't see an improvement from the** |
| 183: | | **medicine** |
| 184: | PAT: | not not in my skin |

The patient's husband asks in line 180 whether the IMG resident is going to refill her Dapsone

prescription.  The IMG resident responds by stating his desire to speak with "the boss", the

attending physician, to *see what he thinks*.  He continues and provides a rationale *I'm not so*

*bottom line*.  With this utterance the IMG resident expresses his lack of commitment to a

treatment decision, which he bases on the patient's lack of improvement after taking Dapsone.

With this idiomatic expression *not so bottom line*, which arguably can be viewed as highly

idiomatic and therefore as an advanced expression for an L2 user, the IMG resident remains

uncommitted and withholds a final judgment about how to proceed with her treatment.

As discussed previously, IMG residents can withhold a treatment recommendation; in 12

of 28 medical encounters this was the case.  However, in this case and as demonstrated in Extract

4.8 in the section above (see "Multi-party talk" section in research question one), the IMG

resident is forced to address the issue of treatment because the patient's husband initiates the treatment advice sequence with a question (though it is not spoken with rising intonation) about a refill. Consequently, with this turn the treatment advice phase is initiated and the IMG resident is compelled to address the husband's question about his wife's future treatment. Instances such as these in which treatment advice is initiated or solicited by either the patient, IMG resident or some other party will receive further examination in the next section.

### Solicited treatment advice.

As discussed previously, the initiation of treatment advice sometimes commences with a question by either the IMG resident, patient, or patient advocate. In this way, the question serves to open up discussion about future treatment options and provides both physician and patient opportunity to state their advice, opinions, and concerns about treatment. In this section, treatment advice that is solicited, as opposed to given spontaneously by either the IMG resident or the patient, will be explored.

Examining the first example, it comes from a follow-up visit with a female patient diagnosed with Sjogren's at the Rheumatology clinic. The patient is currently taking Plaquenil and is responding well to it. As the medical encounter moves into the physical examination phase (this phase is opened up by the IMG resident summoning the patient to the exam table), the patient poses a question to the IMG resident about the Plaquenil medication. She inquires about the continued need to take Plaquenil if she is feeling better. With this move the patient simultaneously takes the encounter into the treatment advice phase. The patient opens up the treatment advice phase with the following solicitation:

Extract 4.18 RHOI001 Sjogren's
139:   PAT:   alright in fact I was kinda wondering if uhm I mean if I'm feeling
140:           better do I have to stay on the Plaqanil or?
141:   FEL:   **yeah so what we could do**

```
142:   PAT:              ((PAT laughs))
143:   FEL:   **actually because your kind of thing and you loss lots of weight uh we**
144:          **could step down once a day**
145:   PAT:   okay
146:   FEL:   ah and then we see how you do on that
147:   PAT:   okay
148:   FEL:   and then (1.0) an then you >can stop it< usually the Plaquenil has a
149:          gradual effect
150:   PAT:   [ºuh uhº right
```

In line 139 the patient utilizes a series of hedges and false starts along with downgraded language to ask whether she still needs to keep taking Plaquenil if she is feeling better. Despite the downgraded language, this question can be interpreted as a rather direct proposal to stop taking Plaquenil. However, the patient ends this interrogative with *or* thus leaving open the possibility of another option or allowing the IMG resident latitude with his answer. Fulfilling the second part of the adjacency pair, the IMG resident takes his turn in line 141 and begins his response to her question. Line 141 initiates his treatment advice response but not until line 143 does the substance of the advice begin. The IMG resident initiates the advice with two justifications – *because your kind* of thing and *you loss lots of weight* – and then provides his treatment recommendation. In this way, the IMG resident does not directly answer the patient's question – does she have to stay on Plaquenil – but rather provides an indirect answer by proposing an alternative option – *we could step down once a day*.

In this treatment recommendation the IMG resident utilizes a basic, indirect declarative formulation consisting of the pronoun *we*, central modal *could* followed by the action verb *step down* (i.e., decrease) and temporal phrase *once a day*, signifying how frequently she would take the Plaquenil in the future. On line 145 the patient accepts this treatment recommendation utilizing the minimal response *okay*. The sequence continues as the IMG resident indicates the

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"wait and see" approach they will take if this modified treatment plan is started. With each turn the patient verbalizes acceptance.

Extract 4.18 illustrates how the patient utilizes an interrogative to solicit treatment advice from the IMG resident. It is important to point out this was one of two examples in the dataset in which the patient becomes an active agent by offering her own suggestion about her treatment going forward. With this patient solicitation we saw how a negotiation between the patient and IMG resident unfolded and developed about the patient's future treatment plan. The patient's initial proposal to possibly stop Plaquenil altogether is not accepted but rather the IMG resident compromises and agrees to lower the medication's frequency. In the next example we will see the IMG resident, not the patient, utilize an interrogative to initiate the treatment advice phase.

The second example is a Neurology consultation with a patient who presents with headaches. The patient is currently taking Amitriptyline and Imitrex. Having just completed his physical examination of the patient's neurological system, the IMG resident moves into the treatment advice phase. This phase of the medical encounter starts as the IMG resident solicits patient input about treatment options for her headaches. It is a rather lengthy extract, which has been divided for analytic and readability purposes, with most of the talk coming from the IMG resident as he presents different medication options to the patient. In Extract 4.19 he recommends a change to her current medication and he also recommends that she start a new medication. The IMG resident starts the extract by saying:

Extract 4.19 NESG003 Headache
95:     RES:   **let's talk now (1.0) what what do you want us to do do you want better**
96:              **control for the headache**
97:     (NUR brings in eye exam tool)
98:     PAT:   I jus want so- m- m- (xx) the medicine that I'm tak- the medicine that my
99:              doctor prescribed fer me
100:    RES:   uhm uh
101:    PAT:   fer the migraines it makes me sic-

102: RES: what medication?
103: PAT: the Im-
104: RES: Imitrex
105: PAT: yeah
106: RES: $^O$kay$^O$
107: PAT: it makes me si- nauseated

The solicitation commences on line 95.  As a means to directly engage the patient in conversation, the IMG resident starts off with *let's talk now*.  This opening phrase suggests that the IMG resident wants to include the patient in the treatment discussion and decision making process.  There is a one second pause, which the patient does not fill, so the IMG resident continues his turn and questions the patient about future treatment options for her headaches.  The sequence is formulated by two successive interrogatives.  The first question – *what do you want us to do* – seems to serve as a basic opener to which the IMG resident is likely expecting no response.  Possibly being caught off guard by the question and with no space provided to respond, the patient leaves the question unanswered.  The IMG resident immediately moves into the next question: *do you want better control for the headache*.  This question serves to directly seek the patient's input into whether she thinks her headaches are severe enough to consider modifying her current treatment plan (the patient is presently taking Amitriptyline and Imitrex).

Taken together, these two questions illustrate how treatment recommendations become co-constructed between physicians and patients.  In this solicitation example, this is most notably demonstrated through pronoun usage.  The use of *us* (*what do you want us to do*) in the first sentence represents the physicians, the clinic, the medical institution charged with treating patients.  The use of *you* (*do you want better control for the headache*) in the second sentence gives agency to the patient to provide input into the treatment decision.  Taken together, the sentences' construction, specifically through pronoun usage, illustrate the jointly constructed nature of the treatment advice phase.  Though the main purpose of these two questions is to open

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up the treatment advice phase, the way they are formulated further serve to demonstrate how

treatment decisions are made collaboratively.

The treatment advice sequence continues and wraps up in the extract below:

116:   RES:   **alright so we can do couple things we can change the Imitrex to**
117:          **something else like uh (xx) an people tolerate the other medications**
118:          **better so we can do that try it**
119:   PAT:                              [<sup>O</sup>uhm uh<sup>O</sup>
120:   RES:   **there is something called uhm Maxalt** I don't know if you've ever if
121:          you've ever used that before
122:   PAT:   no=
123:   RES:   =no okay **let's do that** and uhm we need to bring your headaches under
124:          control
125:   PAT:   uhm uh
126:   RES:   we need to do better with that **so we'll start you some medication fur**
127:          **that one I'm thinking is magnesium the other medication is called**
128:          **Topamax uhm but I think we can start magnesium now and see how**
129:          **you do**
130:   PAT:   uhm uh
131:   RES:   **and ah start Topamax next time** you're already on Amitriptyline a good
132:          dose
133:   PAT:   <sup>O</sup>uhm uh<sup>O</sup>
134:   RES:   does that sound okay?
135:   PAT:   uhm uh

Several turns later on line 116 the IMG resident begins to provide his treatment advice.  He

recommends changing Imitrex, which the patient is currently taking and makes her nauseous,

with *something else*.  Though the new medication he is thinking of goes unnamed, it seems the

main reason he is proposing the new medication is because *people tolerate the other medications*

*better*.  It is likely he is thinking she too will tolerate the medication better, thus relieving her

nausea.  In line 120 he names the medication he is recommending – *Maxalt* and further solidifies

his decision to change medications in line 123 when he states *let's do that*.  It is here that the

IMG resident's first treatment recommendation (to change Imitrex to Maxalt) ends.

The second part of the IMG resident's turn on line 126 begins an additional treatment

recommendation.  Following his stated reasoning that he thinks her headaches need to be better

controlled, he proposes to start some additional medications – magnesium and Topamax.  He

recommends that the patient start the magnesium immediately and start the Topamax in the

future, perhaps after her next follow-up visit.

In comparison to spontaneous advice, as discussed in the previous section, Extract 4.19

illustrates how treatment advice is solicited to open up a discussion of treatment options.

However, once treatment advice commences Extract 4.19 demonstrates that the ways in which

the IMG resident gives advice conforms to the indirect strategies used in other examples.

Hesitations, discourse markers, modalized verb forms, and use of the pronoun *we* are used to get

the patient to do something while mitigating the force of the directive and maintaining harmony

in the medical encounter.

The next extract also demonstrates how the IMG resident moves into the treatment advice

phase through the initiation of a question.  Similar to Extract 4.19, this IMG resident solicits

patient input into the decision making process about her future treatment plan.  As demonstrated

during research question one, this extract shows how multi-party talk is used to jointly construct

the treatment advice phase, facilitate confirmation, and reach consensus about the patient's

treatment.  The extract comes from a Rheumatology follow-up visit with a patient who has

rheumatoid arthritis.  The patient is accompanied by a nurse, who stays in the examination room

with her during the visit. Prior to the start of the sequence, the IMG resident and nurse are talking

about a different topic.  The IMG resident changes topic and starts in:

Extract 4.20 RHOI011 Rheumatoid arthritis
114:   FEL:   **okay so okay so (1.0) shall we change something or not really**
115:   PAT:   huh?
116:   FEL:    **do you feel like we need to change something or not really**
117:   PAT:   hum
118:   NUR:   are you happy with what you're taking now do you feel that=
119:   PAT:   =yeah I'm fine ᴼI'm fine with itᴼ
120:   NUR:   do you feel like he needs to <u>increase it</u> er do you wanna try an <u>decrease it</u>

```
121:        how do you feel?
122:  PAT:  I'd increase a little bit
123:  NUR:  increase it a little bit?
124:  PAT:  maybe see maybe one more tablet maybe I dunno
125:  FEL:  because of the joint pain=
126:  PAT:  =yeah joint yeah joints yeah
127:  FEL:  okay okay so let's call the boss
128:  PAT:  okay
129:  NUR:  boss man ((PAT laughs))
130:  FEL:  and tell him (XX) (basically) we need to increase a little bit and we'll
131:        go from there
132:  PAT:  okay
```

The IMG resident starts the initial treatment advice turn on line 114 with the repetitive use of the discourse markers *okay so*. Following a one second pause, the IMG resident initiates the first of two solicitations seeking the patient's opinion on the way forward for treating her rheumatoid arthritis. The solicitation takes the form of an interrogative – *shall we change something or not really*. The modal *shall* is used, which according to Biber et al. (2002) is sometimes used as a question in conversation where it functions as an offer or suggestion (p. 182). The IMG resident uses the pronoun *we* to emphasize the collaborative decision making process to *change something*. With *change something*, it is likely the IMG resident is referring to one of the patient's current medications, but it is possible something else could also be changed – diet, exercise, or daily activities. To end the turn, the IMG resident uses a coordination tag *or not really* hedging his suggestion to change something. The patient responds with a clarification check *huh* so the IMG resident relies on repetition to restate his solicitation. His second attempt is again formulated as an interrogative – *do you feel like we need to change something or not really*. With the IMG resident's switch from the modal *shall* to *need to*, functioning as a semi-modal of obligation or necessity, it appears he is upgrading the force of the directive portion of the turn. Once again, this second solicitation attempt is hedged through the use of *or not really* and is met with minimal response by the patient.

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At this point in the conversation the nurse joins in and over the next several turns attempts to elicit a response from the patient. In line 122 the patient finally provides a response indicating her preference to increase her medication as she says *I'd increase a little bit*. The IMG resident chimes in on line 125 providing a rationale from the patient as to why she would like to increase a bit. Finally, starting on line 127 the IMG resident begins to wrap up the sequence, this phase of the medical encounter, and signals his next course of action to begin the joint interaction (*okay okay so let's call the boss*). The wrap-up continues on line 130 as the IMG resident provides a summarization of the jointly constructed verdict to *increase a little bit* her medication. It appears clear however that this recommendation may not be the final verdict as the IMG resident's allusion to his attending physician makes known that he may also have an opinion on the proposed treatment decision. Moreover, his use of *we'll go from there* at the end of the turn appears to leave the door open for an alternative decision; his attending physician may not agree with or may want to modify the recommended treatment plan to increase the patient's medication.

These examples illustrate how interrogatives are used in the treatment advice phase. Interrogatives, like those seen in Extracts 4.18, 4.19 and 4.20, work to serve two purposes: 1) provide an opening into the treatment advice phase and; 2) solicit patient input into the treatment decision-making process. As these examples illustrate, solicitation can be sought from both patients and physicians. The act of soliciting input in this way highlights the ways in which treatment decision-making can be jointly conducted. The very activity of bringing someone into the decision making process through input solicitation is an act of collaboration. As these examples demonstrate, how physicians and patients initiate and respond to these acts of collaboration yield varying forms, results, and decisions that impact the advice giving process.

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**Future advice**

The previous sections have focused on the giving of treatment advice that requires immediate acceptance and implementation. In other words, with the next prescription refill or by the next appointment the patient is expected to modify their treatment to incorporate the recommended treatment advice. For instance, if the recommendation was to start a new medication, the patient should start it sooner rather than later. In some instances, however, the treatment advice phase becomes a discussion about treatment decisions that may be delayed or occur sometime in the future. In other words, what I plan to contrast here are immediately occurring actions a patient may enact based on the treatment advice decisions made during the medical visit versus future or delayed actions a patient may take based on discussion and decisions made during the treatment advice phase. Vine (2004) uses the terminology NOW or LATER to distinguish between those directives that occur or "require immediate compliance (NOW) versus those where the completion of the action will be delayed to another place and time" (LATER) (p. 32). The extracts examined up to this point have been of the NOW variety with the expectations that patients' actions to modify their treatment plans will transpire in the immediate course of time. Explored below, and following Vine's (2004) definition, will be examples that occur in the future or are of the LATER variety of directives.

The first example comes from a follow-up visit with a patient diagnosed with rheumatoid arthritis in the Rheumatology clinic. The patient is presently taking Methotrexate and a host of other medications. During the visit the patient's treatment plan is not changed, however the IMG resident pursues discussion during three separate episodes with the patient that Methotrexate may need to be stopped because there is a possibility that it is causing the patient lung issues. After a discussion of the patient's lungs and the factors (e.g., tuberculosis, rheumatoid arthritis,

Methotrexate) that may be contributing to her problems, the IMG resident proposes the

possibility of stopping Methotrexate.

Extract 4.21 RHCG008 Rheumatoid arthritis
140:   FEL:   well the thing is that **we may have to discontinue the Methotrexate**
141:   PAT:   ah then somethin'll bother me
142:   FEL:        [if
143:   FEL:   exactly uh and and if we're gonna continue stapering tapering your
144:            steroids then obviously your rheumatoid is gonna flare up=
145:   PAT:   =right=
146:   FEL:   =so we have to establish what the findings in your lungs are
147:   PAT:                                 [what
148:   PAT:   okay
149:   FEL:   **if there is evidence of Methotrexate damage then we have to stop**
150:            **Methotrexate**
151:   PAT:     [before we go any
152:   PAT:   okay
153:   FEL:   **uhm and if we stop Methotrexate? we: may need to start Remicade**
154:   PAT:                                                 [Remicade
155:            almost immediately because when we went back on the Methotrexate I
156:   FEL:               [uhm:
157:   PAT:   started to do so much better

This sequence and the way in which the IMG resident proposes a modification to her treatment

plan is primarily expressed through the use of modalized verbs and conditionals. In line 140 the

IMG resident tells the patient *we may have to discontinue the Methotrexate*. To formulate this

future treatment advice she uses the collaborative *we* and follows it with a string of modalized

verbs *may have to* expressing the possibility that it may be necessary for the patient to

*discontinue the Methotrexate*. The patient and IMG resident continue discussing the possible

discontinuation and associated concerns. Then on line 149 the IMG resident begins the turn with

a conditional. In this conditional formulation *if there is evidence of Methotrexate damage then*

*we have to stop Methotrexate* the IMG resident restates the need to stop Methotrexate but

embeds it in the condition of evidence of lung damage caused by Methotrexate use. Three turns

later the IMG resident extends the logical consequence of the first conditional and states *if we*

*stop Methotrexate we may need to start Remicade*. In this turn on lines 153 the IMG resident

again uses a conditional to express the possibility that the patient may need to start another

medication (Remicade) in the event Methotrexate is stopped.

Taken together, these three turns (lines 140, 149-150, 153) by the IMG resident

demonstrate how declaratives are used to propose to the patient LATER treatment actions. In

her formulations, the IMG resident relies on modalized verbs (*may have to*, *have to*, *may need to*).

Moreover, it can be argued that the uses of the central modal *may* in *may have to* (line 140) and

*may need to* (line 153), in contrast to *have to* (line 149), serve as the more polite form leaving

open the possibility of some alternative course of action. In addition, the IMG resident utilizes

conditionals to provide reasons or conditions for her proposal to discontinue Methotrexate in the

future and start the patient on Remicade.

Taking a look at another example of future advice, Extract 4.22 also comes from a

follow-up Rheumatology visit. A different extract from this interaction was previously presented

in research question one (see "Patient initiated advice" section). The patient is diagnosed with

Ankylosing Spondylitis and takes the medications Meloxicam, Gabapentin and Amatriptyline.

During the joint interaction phase it was negotiated that the patient would restart the medication

Sulfasalazine. However, during the solo interaction between IMG resident and patient they

discuss the possibility of starting a *stronger* medication (stronger than Sulfasalazine) in the

future as shown here:

Extract 4.22 RHOI006 Ankylosing Spondylitis
167:    FEL:    uh it didn't show any inflammation there but your symptoms are so
168:            classical of something inflammatory going on so uhm we just have to wait
169:            an monitor and make sure that nothing is popping up
170:    PAT:    okay
171:    FEL:    **if it <u>does</u> then you we may need to change directions**
172:    PAT:    so we just keep monitoring until something else changes?
173:    FEL:    if (ever)

| 174: | PAT: | okay <u>if</u> anything changes |
| 175: | FEL: | if everything changes |
| 176: | PAT: | now what about all this going on in my hands an my joints |
| 177: | FEL: | right so:: this is why I'm asking how bad you are uhm or if you think that |
| 178: | | you're bad enough to start something else or not really |
| 179: | PAT: | we- start what though |
| 180: | FEL: | uh:: |
| 181: | PAT: | are you talkin injections? |
| 182: | FEL: | no no no |
| 183: | PAT: | oh okay |
| 184: | FEL: | **I'm talking about uh::: pills that they kind of decrease the immune** |
| 185: | | **system uhm** |
| 186: | PAT: | [uh::: |
| 187: | FEL: | **like the Sulfasalazine** but kind of stronger than that so this is the question |
| 188: | | this is the thousand dollar question |
| 189: | PAT: | tch(h)yeah uhm |
| 190: | (2.0) | |
| 191: | FEL: | **an >we don't have to make< this decision now** |

At the end of this sequence in line 191 the IMG resident declares *an we don't have to make this decision now* thus making it known to the patient that he is not recommending a change to her current treatment plan but rather proposing a change for the future.  Similar to Extract 4.21 this IMG resident also uses the conditional *if* and the modal construction *may need to* in line 171 to propose his future treatment advice.  Unlike Extract 4.21 in which the IMG resident specifically names the medications she is talking about (Methotrexate, Remicade), this IMG resident does not name the medication but rather compares it to another medication Sulfasalazine.

These two examples begin to paint a picture as to how IMG residents give future treatment advice to patients.  In both extracts the IMG residents use modal verbs to express possibility and necessity to change course in the future.  Additionally, conditionals expressed through the use of *if* are utilized to express the existence of certain circumstances under which it may be advised that patients modify their course of treatment.

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**Conclusion**

In conclusion, this section has demonstrated how IMG residents overwhelmingly utilized declaratives to give treatment recommendations to patients. Only one imperative was used in the form of *let's* + verb. The data also showed that the directives were formulated using various indirect strategies, which attenuated the force of the treatment recommendations. This indirect strategy to formulate advice aligns with Harrison and Barlow's (2009) study, which showed that participants in an online arthritis forum also used indirect strategies to deliver advice to fellow participants (p. 106). In addition, these data demonstrate that hesitations (e.g., *uh*) hedges (e.g., *maybe*, *probably*), discourse markers (e.g., *okay so*), and tags (e.g., *okay*, *or not really*) pervaded the IMG resident's discourse. These mitigation strategies are commonplace in everyday conversation, however in institutional discourse they additionally serve to mitigate the force of directives and work to lessen institutional role asymmetries, in this case between physician and patient (Holmes & Stubbe, 2003). In addition, IMG residents frequently utilized the pronoun *we* when giving treatment advice. This usage seems to suggest they recognized the giving and accepting of treatment as a collaborative process within the medical institution, involving both physicians and patients. Modalized verbs, both modal and semi-modal, were also a common feature of IMG residents' declaratives. Constructed as modals, declaratives sound less direct and forceful to the recipient, in this case the patient; as a consequence of this mitigated construction, the patient may perceive choice or further discussion is permissible. Additionally, on some occasions during the treatment advice phase IMG residents made vague reference (e.g., something, more medications) to the medication they were recommending. Advice constructed using vague terminology may demonstrate an uncertainty or an unwillingness to commit to a

specific medication. Moreover, this uncertainty led IMG residents in some instances to cede

treatment advice authority to their attending physicians.

In this section I also made a distinction between spontaneous and solicited treatment

advice. With spontaneous treatment advice IMG residents provided their recommendation

during different points in the conversation with the patient. In other words, it was not always

predictable or determinable when the IMG resident would provide treatment advice to the patient,

if at all. As the data showed, treatment advice may be delivered during a discussion about

medications the patient is currently taking or it may occur during or after a separate topic (e.g.,

discussion about a specialist). In comparison to treatment advice of a spontaneous nature,

solicited treatment advice was initiated through the use of interrogatives. These interrogatives

functioned as openers to a conversation about treatment. Additionally, the interrogatives served

to bring the patient into the treatment decision making process and demonstrated how the

treatment advice phase was constructed jointly.

The data also contained two examples of future treatment advice. As discussed in this

section, LATER treatment advice was contrasted with NOW treatment or treatment that requires

immediate attention. These data were characterized by the use of conditionals and modalized

verbs. Conditionals were utilized and in both instances made reference to a change in the

patient's condition (e.g., if there is evidence of Methotrexate damage) that may dictate a

modification to the patient's future course of treatment. Additionally, when giving future

treatment advice IMG residents continued to rely on modalized verbs.

In this section the IMG residents received primary focus as I examined the ways in which

they delivered treatment advice. In the next section I explore the flipside of the interactional

equation so to speak to examine patients' responses to treatment recommendations.

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**Research Question Three**

What is the relationship between the nature of the directives and patients' responses, including expressed likelihood of following the IMG residents' treatment advice?

In the previous section examining research question two, I explored the ways in which the IMG residents provided treatment advice to their patients. Taking a discursive approach requires that all participants in conversation, in this case primarily the physician and patient, receive uniform consideration as regard their contributions to the unfolding interaction. Moreover, the co-constructed nature of the treatment advice interaction, as previously demonstrated, highlights the fact that in this phase of the medical encounter interaction both participants' contributions work jointly to come to a decision about treatment. Consequently, in this section and after previously examining the IMG residents' contributions, focus turns to the patient as I examine the ways in which patients respond to the advice given. In addition, in this section I will also examine the expressed likelihood that the patient will follow the treatment advice.

Health communication research demonstrates that patient's participation tends to occur through the use of minimal responses during medical encounter interactions (Robinson, 2003; Street & Millay, 2001). For example, research has shown that during the history-taking phase physicians tend to control the questions, which are oftentimes formulated as dichotomous, *yes/no* questions, thus requiring a one-word response from the patient (cf. Stivers & Heritage, 2001). In the diagnostic phase of the medical encounter, research has shown that patient's submit to medical authority due to the fact the activity requires specialized medical and technical knowledge. Consequently, patients' participation and responses are oftentimes curtailed during this phase. (Heath, 1992; Heritage & Clayman, 2010; Peräkylä, 1998) (cf. Peräkylä, 2002).

Research examining the treatment advice phase of physician-patient interactions demonstrates that while patients may still respond minimally, a response is expected and in some instances pursued by the physician.  Previous healthcare research and the research presented here demonstrate that a treatment recommendation sequence requires both the delivery of the recommendation and the acceptance or rejection of the recommendation (Heritage & Sefi, 1992; Koenig, 2008, 2011; Lepännen, 1998; Stivers, 2006).  In other words, both participants in the advice giving and receiving sequence jointly orient to and negotiate the sequence thus warranting it as a shared decision-making activity.  Furthermore, research on the treatment advice phase demonstrates that patients utilize different response strategies.  Patients typically respond in one of three ways:  with agreement, with passive resistance (withhold acceptance) or with active resistance (Koenig, 2008, 2011; Stivers, 2006)

In this section my analysis will demonstrate that these data align with previous treatment advice research showing that some patients utilize minimal responses while engaging in interaction.  In addition, the data reveal that patients use non-minimal responses to seek additional information or clarification through the use of interrogatives.  Moreover, due to the fact that some treatment advice sequences solicit patient input, patients do not respond minimally but in fact are compelled to provide an extended answer in response to the treatment advice solicitation.

Given the fact the primary focus of this dissertation is on the interactions between IMG residents and patients, the data from the solo interactions will receive primary attention.  However, data from two other sources will also be used, where available, to provide additional supportive evidence.  As highlighted in the section addressing research question one, it is possible for the patient to receive two treatment recommendations:  one recommendation during

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the solo interaction with the IMG resident and a second recommendation during the joint

interaction with the attending physician and IMG resident.  Thus, data from the joint interactions

will serve as supportive evidence.  Due to the fact patients must also attend and respond to the

treatment advice given during the joint interactions, these interactional data focusing on patients'

responses will be used to corroborate or complicate the solo interaction data.  The additional

secondary data source will come from the post-medical encounter survey completed by the

patient.[22]  Specifically, two questions from the patient survey provide valuable insight to aid in

the analysis and determination of the patient's expressed likelihood to follow the treatment

advice.  The two survey questions that will be utilized are:

1. Question four – If yes, can you please describe, as completely as possible, the treatment

   the doctor recommended?

   If the patient responded "yes" to question three asking – "In your office visit today, did

   the doctor offer you any treatment?" – then the patient proceeded to question four.  This

   question allowed the patient to provide an open-ended response.

2. Question nine – How likely are you willing to follow the doctor's recommended

   treatment?

   Patients were provided the following responses from which to select:

   a. Very likely

   b. Likely

   c. Unsure

   d. Unlikely

   e. Very unlikely

---

[22] As noted in Chapter three, in some instances the patient did not complete the post medical encounter survey.

The purpose for using these additional data sources is data triangulation allowing me to formulate a more holistic interpretation of the patients' responses and involvement during the treatment decision-making process. Additionally, taken together these three data sources will allow for a determination to be made as to the patients' willingness to follow the treatment recommendations, leading, in turn, to arguably more favorable health outcomes and patient satisfaction.

**Patient ambivalence toward treatment recommendation.**

Turning to the first example, there are times when the physician's treatment recommendation is met with indifference or ambivalence despite the physician's orientation to the pursuit of patient participation in the treatment advice phase (Stivers, 2006). In other words, the patient's response, manner, or lack of response may indicate indecision on the patient's part thus raising uncertainty about the likelihood to follow the treatment recommendation. In these instances, the physician may or may not pursue further the patient's acceptance.

This first example is a follow-up visit that takes place in the Rheumatology clinic with a female patient diagnosed with lupus. As treatment the patient has been prescribed Plaquenil, which she is supposed to take two times per day. During the solo interaction with the IMG resident the patient states she has been resistant to taking her medication as prescribed because she is in denial about the lupus diagnosis. This section of the interaction occurs toward the end of the solo interaction. The IMG resident starts in:

Extract 4.23 RHCG005 Lupus (Solo interaction)
```
76:   FEL:  …Plaquenil's a pretty safe medication so: I know you you were reluctant
77:         to do the twice daily but I mean really I think eve- every rheumatologist
78:         will tell you they would take it in a minute and they don't have any
79:         problems like if it's their family they wouldn't have any problems
80:         recommending it the only thing that it may cause is that problem with the
81:         eyes but we send you to check and it's very uncommon that it happens so
82:         uhm and it helps a lot of people feel better it also prevents flares uhm
```

83:          <u>helps</u> prevent flares
84:    (1.0)
85:    PAT:    **now the lupus we have stairs at my house**

In her extended turn (lines 76-83) the IMG resident utilizes a highly indirect approach to

recommend treatment to the patient. That is to say, rather than directly telling or reminding the

patient to take Plaquenil as prescribed (two times per day) the IMG resident utilizes an

educational-based, patient-centered approach as a way to give treatment advice (see section

"Patient Education" in research question four for a further discussion). In this way, although the

IMG resident's formulation contains detailed and arguably persuasive information, the turn's

design leaves agency with the patient providing her latitude to do what she will with the

information.

What, in fact, does the patient do with the information just received? In other words,

what response does the patient provide? In the next turn, after a one second pause, the patient

changes topic and says *now the lupus we have stairs at my house*. With this change of topic turn,

the patient fails or chooses not to acknowledge any of what the IMG resident has said.

Moreover, she provides no excuses for not taking the medication as prescribed. Furthermore, her

response provides no indication as to whether she will plan to take Plaquenil two times per day

in the future. With this response the patient remains somewhat silent on the topic of her

treatment plan. It remains uncertain how the treatment-related information provided by the IMG

resident may affect the way the patient takes the prescribed medication in the future.

Given the dual opportunities for treatment advice in these medical encounter data, we

have an additional chance to observe how the patient responds during the joint interaction. Prior

to Extract 4.24 the IMG resident presents the patient's history and current treatment plan to the

attending physician.  The delivery of the treatment plan begins on line 131 as the attending

physician states:

Extract 4.24 RHCG005 Lupus (Joint interaction)
131:    ATT:    and so so what we need to do is we'll continue your Plaquenil two pills a
132:            day one it just take both at the same time and you check your eyes once a
133:            year
134:    PAT:    **ta take em take the both at the same time?**
135:    ATT:    uhm uh
136:    FEL     yeah you can take them both at the same
137:    ATT:    yeah it doesn't matter once or twice you know sometime if you do it twice
138:            you might forget it you know at the end of the day so just take it at the
139:            same time now…(attending physician reminds patient to cover herself
140:            when in the sun to prevent "full blown" lupus)
141:    PAT:    **uhm**
142:    ATT:    like starting affect your kidney er your heart er your lungs everything so
143:            those are the things we wanna prevent now okay and uh do sun blocks
144:            and also we need to do your blood tests once everything three ta six
145:            months…
146:    PAT:    **kay**
147:    ATT:    okay? an then anything on your joints…

During this section of the interaction the attending physician makes his treatment

recommendation: *we'll continue your Plaquenil two pills a day*.  The advice is to stay the course

with the current treatment plan.  Moreover, the advice is in alignment with the IMG resident's

discussion with the patient during the solo interaction.

During this sequence, the patient takes her first opportunity to respond to the advice on

line 134.  In this turn she asks the question – *ta take em take the both at the same time* – to clarify

the treatment information provided.  In response to her question, both attending physician and

IMG resident provide an affirmative answer in lines 135 and 136, respectively.  Given the

patient's hesitancy to take Plaquenil two times per day, this question and answer sequence may

serve to provide the patient with the additional information she needed to take the medication as

prescribed.  In other words, it is possible she did not know or had not been previously informed

that Plaquenil could be taken this way.  Consequently, this new information may provide the answer the patient wanted or needed to be in compliance with her treatment plan.

In a similar manner as the solo interaction, the attending physician uses this sequence to provide patient education about living with lupus.  To these educational turns, the patient responds minimally with *uhm* in line 141 and *kay* in line 146.  In line 147 the attending physician attempts to close the sequence down by utilizing a rising intonation *okay* but provides no opportunity for a response as he maintains the floor and changes topic to her physical symptoms (not shown in Extract 4.24).  In the remainder of the medical encounter, neither physician returned to the topic of treatment except to ask the patient whether she needed a prescription refill.

Examining the patient's responses in both the solo and joint interactions we see that the treatment recommendations, offered utilizing indirect and direct formulation strategies, are not readily agreed to by the patient.  With the exception of the clarification question in Extract 4.24 during the joint interaction we are offered little insight as to whether the patient agrees or disagrees with the physicians' treatment recommendation.  So, with scant evidence from the interaction data about what the patient thinks, does the survey data provide any additional supporting evidence?  To question four on the post-medical encounter survey, asking to describe the treatment recommendation, the patient provided the following answer:  *They both recommended that I continue with 2 Plaquenils a day (at the same time) and do follow up's every 4-6 months*.  With this survey response the patient answers with the exact medication details (i.e., medication, dosage, and frequency) provided by the physicians.  Furthermore, she takes into account the fact that both physicians provided the same recommendation.  In answer to question nine on the survey asking how likely she is willing to follow the treatment recommendation, the

patient answered that she is *likely* to follow it.  Consequently, with these post-medical encounter

survey results we are able to get some indication that the patient may consider becoming

compliant with the previous and current treatment recommendation to increase the Plaquenil

dosage.  However, it is important to point out that she selected *likely*, not *very likely*, as regard

her willingness to follow the recommendation, thus leaving open the possibility that she still

needs to further consider this recommendation.  Therefore, the possibility remains open that she

may maintain the dosage amount at one Plaquenil a day.

**Patients' agreement with the treatment recommendation.**

In contrast to the example presented above, the patient in the next example utilizes her

responses to display agreement with the treatment recommendation.  This medical encounter,

previously presented in the section analyzing research question one, comes from a follow-up

visit in the Rheumatology clinic with a female patient diagnosed with rheumatoid arthritis.  The

treatment recommendation sequence during the solo interaction goes as follows:

Extract 4.25 RHOI009 Rheumatoid arthritis (Solo interaction)
101:    FEL:    so the question is if we should do something more 'bout your uhm like
102:            increasing a little bit the Methotrexate uhm
103:    PAT:    **fur the wrists**
104:    FEL:    yeah you still have >a little bit of:< active disease there uhm (1.5) an if
105:            you tolerate it well
106:    PAT:    **uhm uh yeah**
107:    FEL:    you should be okay an your labs looks great so
108:    PAT:    **uhm uh mkay**
109:    FEL:    let me go an find the boss

In Extract 4.25 the IMG makes his treatment recommendation in line 101, proposing that

the dosage of Methotrexate be increased *a little bit*.  The open-ended recommendation

formulation leaves open several possible response options.  However, the patient utilizes a

question – *fur the wrists* in line 103 to seek clarification from the IMG resident that he is

considering increasing Methotrexate because of her continued wrist pain.  To this question the

IMG resident affirms the patient's thinking and provides several accounts for his

recommendation. In the midst of his accounts and as a way to demonstrate active listenership

(Farr, 2003; Knight & Adolphs, 2008; McCarthy, 2003), the patient acknowledges the IMG

resident's explanation with *uhm uh yeah* in line 106. The IMG resident provides one more

justification for his recommendation to increase Methotrexate to which the patient responds with

the agreement tokens *uhm uh mkay* in line 108. It is apparent the IMG resident treats this

response as agreement thus allowing him to close down the treatment advice sequence and the

solo interaction in line 109 with *let me go an find the boss*.

Extract 4.25 shows how the patient uses a clarification question and minimal but

agreeable response tokens to respond to the IMG resident's treatment recommendation. Having

received a response to her clarification question to which she apparently agrees (i.e., she agrees

her wrists are still sore and painful), the patient demonstrates her agreement in lines 106 and 108

and remains engaged in the treatment advice sequence. Now taking a look at the joint interaction

phase, Extract 4.26 below shows that the attending physician makes the same treatment

recommendation to increase the Methotrexate dosage.

Extract 4.26 RHOI009 Rheumatoid arthritis (Joint interaction)
```
178:   ATT:   so I think the thing that makes the most sense at this point since you
179:          tolerate the Methotrexate is go up to eight tablets which is kind of our
180:          maximum dose
181:   PAT:   mkay
182:   ATT:   hopefully that'll getcha where ya need to be and hopefully there'll be no
183:          new changes on the x-rays
184:   PAT:   okay
185:   ATT:   but if the eight tablets isn't enough ta completely get rid of it or if we start
186:          to see new damage on the x-rays then we might have ta ramp
187:   PAT:   alright
188:   ATT:   therapy up a little bit you start to get more infections or have more
189:          problems with that then call us and let us know
190:   PAT:   okay
```

In the interaction between the attending physician and patient we see that the patient remains agreeable to this recommendation to increase Methotrexate as demonstrated by her use of the agreement response token *mkay* in line 181. Her engagement in the interaction continues as she acknowledges and continues to agree with the attending physician's additional treatment-related turns (in lines 184, 187, and 190). These listener response tokens serve multiple functions in that they show active participation in the treatment advice sequence, demonstrate agreement, and maintain good relations between participants.

In the post medical encounter survey the patient provided the answer *concerned about my pain level* to question four asking to describe the treatment recommended. This response does not explicitly answer the question; rather, the description appears to summarize the consensus reached about her arthritic condition. In response to question nine asking how likely she is willing to follow the treatment recommendation, the patient answered *very likely* to follow the recommendation. With this *very likely* response it seems apparent that the patient will continue to take Methotrexate as previously prescribed.

Taken together, the analysis of the solo and joint interactions coupled with the patient survey data show that given the patient's continued active disease, mainly in her wrists, the physicians recommended an increase in the Methotrexate dosage. During the treatment advice sequences in both the solo and joint interaction phases the patient's turns display agreement with this recommendation. It seems reasonably clear that the patient intends to take Methotrexate as previously prescribed. What remains unclear is whether the patient understood or is willing to follow the advice to increase the Methotrexate dosage. Given the opportunity to document her perceptions of the medical encounter, the patient utilized her agency to highlight her health and symptomatic condition instead of focusing on the explicit treatment for such condition.

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Consequently, while this answer does not serve as contradictory evidence, it does limit the possibility to say with certainty that she will increase the dosage as recommended during this medical encounter interaction.

In the next medical encounter example we see a patient who also responds agreeably to the proposed treatment recommendation. Additionally, this example demonstrates the patient's active participation in the treatment advice sequence given the solicitation used to open up one of the sequences. The medical encounter occurs with a female patient following up on her rheumatoid arthritis condition at the Rheumatology clinic. To treat her rheumatoid arthritis symptoms the patient is taking the medication Methotrexate. During the opening phase of the visit the patient mentions "some lingering pain" she continues to experience. The IMG resident initiates the treatment advice sequence during the solo interaction with a solicitation to the patient seeking her opinion about her future treatment. The IMG resident starts in:

Extract 4.27 RHCG003 Rheumatoid arthritis (Solo interaction)
72:    FEL:   a:nd do you think you're at a point where you would want to <u>add</u> more
73:            treatment or like the Leflunomide uhm or you'd still rather hold off and
74:            stay where you are right now
75:    PAT:   **I I may like to add something else in because I think I don't feel like**
76:            **I'm getting the full you know the full benefit that I was before**
77:    FEL:   uh uh

In lieu of making a treatment recommendation during this short interaction between IMG resident and patient, the IMG resident instead takes a patient-centered approach seeking input from the patient about what she would like to do. In her solicitation formulation the IMG resident presents two options: *add more treatment or like the Leflunomide* (in lines 72-73) or *you'd still rather hold off and stay where you are right now*. Presented in this manner, this formulation may function in a couple of different ways: it proposes the treatment options the IMG resident herself may be considering and with only two options presented it may serve to

limit the treatment possibilities from the patient's perspective, thus possibly constricting her response.

Given the opportunity to participate in the treatment decision, the patient offers her response in lines 75-76. She states in a carefully and tentatively constructed manner that she is in favor of adding some additional treatment (*I I may like to add something else in*) and provides a justification for her decision (*I don't feel like I'm getting the full you know the full benefit that I was before*). With this response the patient does not name a particular medication and in so doing indexes the role of the non-consumer layperson. By this I mean she knows her symptoms are bad enough to require additional treatment but she chooses not to or has not made herself expert enough to suggest a medication. On the contrary, by offering the evaluation that with her current course of treatment she is not getting the *full benefit* that she was before, she takes an evidential stance demonstrating knowledge and awareness about how medications ameliorate her arthritic conditions and make her feel overall. In sum, this patient's response demonstrates personal responsibility, agency, and self-awareness concerning her rheumatoid arthritis and how she wants to treat it so that her symptoms are controlled and her overall health and lifestyle improves.

The joint interaction, presented in Extract 4.28 below, involves many more turns in comparison to the solo interaction and involves all three participants – the patient, the IMG resident, and the attending physician. They had just completed discussing the patient's recent labs as the attending physician opens up the treatment advice phase in line 314 below:

Extract 4.28 RHCG003 Rheumatoid arthritis (Joint interaction)
314:    ATT:   uh now so there's two options you know number one we really wanna be
315:              more aggressive on the treatment?=
316:    PAT:   **=yeah I think so**
317:    ATT:   so one is really one option is the research which logistically is not possible
318:    PAT:   **uhm uh**

319:  ATT:  injectables maybe we're gunna fight with your insurance again
320:  PAT:  yeah probably probably ours has been steadily decreasing in the
321:        coverages the years going
(Continues short discussion about patient's insurance company)
328:  ATT:  so the third option we can do is real- which is (0.5) relatively comparable
329:        >°to injectables°<
330:  PAT:                                                                    **[uhm uh**
331:  ATT:  so we're gunna do a triple combo treatment
332:  PAT:  **okay**
333:  ATT:  so we're gunna add on Sulfasalazine and Plaquenil
334:  PAT:  **okay**
335:  ATT:  are you allergic sulfa medication
336:  PAT:  I oh I can't yeah I cannot do sulfa I will have a rash an the whole bit I've
337:        done that I I'm allergic to sulfas and to penicillin
338:  ATT:                  [mhm::
339:  FEL:  °oh°
340:  ATT:  what we're gunna do now is we can we're just gunna do proport- how
341:        much you're point seven right? point seven ah
342:  PAT:  yeah point seven I've been up to point eight without having too much
343:        reaction cuz we've done that before an (XX)
344:  ATT:  (that's right) we'll yeah so first thing is like seventeen point five
345:        milligrams
346:  PAT:  **okay I don- I don't know**
347:  FEL:  yeah we can (xxx)
348:  PAT:  I just know how m(h)uch is in (X)
349:  ATT:  so what what we can do is we can add on Arava so we'll do a combo of=
350:  PAT:  **=okay**
351:  ATT:  Methotrexate and Arava=
352:  PAT:  **=okay**
353:  FEL:  so no increase in the Methotrexate
354:  ATT:  yeah because you gunna add if we gunna add Arava
355:  FEL:          [until we
356:  ATT:  then usually don't wanna max out >Methotrex< so you'll stay fifteen
357:        seven point five is okay
358:  PAT:  **okay**
359:  ATT:  but at least we'll put in Arava an try to see how you feel clinically and also
360:        your laboratory make sure everything's (X) control your inflammation (X)
361:  PAT:  **okay that sounds great yeah**

With the attending physician's turn in line 314 to open discussion of future treatment for the

patient, he indicates two treatment options that go unnamed at this point and he emphasizes the

need *to be more aggressive on the treatment*.  This statement affirms the patient's evaluation of

her current condition and treatment made during the solo interaction in lines 75-76.  The patient

takes no time to respond to the attending physician as she latches her response of agreement *yeah I think so*. Over the next several turns the attending physician lays out his three treatment recommendations, two of which he outright dismisses. With each turn the patient responds with continuers (i.e., *uhm uh*) (Schegloff, 1982) and a turn in lines 320-321 in which she agrees with the attending physician about the lack of injectables coverage from her insurance company.

As this sequence progresses and a treatment recommendation is finally reached in lines 349 and 351to do a combination of Methotrexate and Arava, the patient remains engaged in the conversation. Her engagement is demonstrated through the use of minimal response tokens and extended turns of talk. The patient frequently utilizes a freestanding *okay* (lines 332, 334, 350, 352, and 358) to respond to the attending physician's previous turn. *Okay* is used frequently in American English (see Metcalf, 2011 for a thorough discussion) and can serve different functions, such as signal continuation, receipt of information, or agreement (Gardner, 2001; O'Keeffe & Adolphs, 2008). I contend here that in each of her turns the patient's usage of *okay* functions as an agreement token (cf. Heritage & Lindström, 2012). Moving into the joint interaction the patient had already verbalized that she wanted to *add something else* to her current treatment plan and in line 316 she agreed with the attending physician that moving forward they should become more aggressive with treatment. Consequently, the tenor of the interaction had been previously set on a trajectory of agreement and alignment as regard the patient's future treatment plan. Therefore, the repeated utilization of *okay* signals agreement and also works to maintain harmony between participants. The patient ends the treatment advice sequence in line 361 with an extended engagement response *okay that sounds great yeah*. Her response works to endorse the treatment recommendation with even greater enthusiasm as before and as her final response it works to close down this sequence with treatment agreement reached.

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With this medical encounter there is no survey data with which to triangulate the interactional data. However, in this case the interaction provides sufficient evidence to argue that the patient supports the treatment recommendation. It seems reasonably clear that she will plan to start Arava and continue taking Methotrexate.

**Patients' utilization of questions.**

As demonstrated in the examples presented thus far, some patients have utilized questions to seek clarification and additional information specifically and to remain engaged in the interaction more generally. In this section I present two examples in which patients rely heavily on the utilization of interrogatives for different purposes while remaining engaged in the treatment recommendation phases. The first example, also presented in research question two, is a new patient visit in the Neurology clinic. The patient is seeking a diagnosis and treatment for the tingling, numbness, and pain he is experiencing in his extremities. The treatment recommendation from the IMG resident in the solo interaction occurs while the patient and IMG resident are discussing the patient's current medication.

Extract 4.29 NEOK004 No diagnosis (Solo interaction)

```
77:     RES:   mhm mm (13.0) okay so you're taking Amlodipine aspirin hypertensive
78:            medication you're taking are you not taking Neurontin?
79:     PAT:   uh?
80:     RES:   Neurontin Gabapentin
81:     PAT:   I'm takin that
82:     RES:   yeah so this (XX)
83:     PAT:   Gabapentin
84:     RES:   it doesn't work
85:     PAT:   it work a little bit but sometime it don't work
86:     RES:   okay maybe we could amp up a little bit more are you taking one
               hundred milligram?
87:     PAT:                                               [huh?
88:     PAT:   of what?
89:     RES:   Gabapentin
```

In this section of talk the IMG resident verbalizes a recommendation to increase one of

the medications (Gabapentin) the patient is currently taking in line 86.  While making the

recommendation, the patient overlaps with a minimal *huh?*, which receives no uptake by the

IMG resident as she completes her verbalization with a question to the patient about current

medication dosage.  This dosage question gets no answer as the patient tries again in his next

turn to clarify what the IMG resident is talking about; in line 88 his question, *of what*, becomes

more specific, seeking to clarify what medication the IMG resident is recommending to increase.

In response to the question the IMG resident names the medication – Gabapentin.  For the next

several turns the patient and IMG resident continue to discuss the current Gabapentin dosage he

is taking.  As mentioned previously (see "Spontaneous treatment advice" section in research

question two), during the closing phase of the solo interaction the IMG resident again

recommends that they possibly increase his medication.  To this turn (data not shown) the patient

responds minimally with *uhm uh*.

Turning to the joint interaction phase, we will see that the patient makes greater use of

interrogatives as compared to this brief interaction with the IMG resident.  Extract 4.30 below

displays the treatment advice sequence that occurs between patient, attending physician, and

IMG resident.

Extract 4.30 NEOK004 No diagnosis (Joint interaction)
156:    ATT:    … so we'll check so he do- has no (X) reflexes right ah so we'll check
157:             we'll do a study of your nerves also malright? and we'll increase the dose
158:             of your medication pain medication now wh- wh- his kidney eh we have
159:             to be careful with the by the way with the kidney uh
160:    RES:    Gabapentin
161:    ATT:    yeah because the Gabapentin we'll increase two hundred three times a day
162:             because he has renal failure
163:    RES:    oh okay so two hundred tid
164:    ATT:    no one hundred three times a day
165:    RES:    okay yeah
166:    ATT:    uhm uh instead of three because

| 167: | RES: | yeah |
|---|---|---|
| 168: | ATT: | he has problem clearing the |
| 169: | RES: | (X) okay |
| 170: | ATT: | (XX) hangs around for a longer period of time |
| 171: | RES: | uhm uh |
| 172: | ATT: | so stay right here we'll give you those prescriptions okay? |
| 173: | | and we'll give you we'll increase the dose of this medication that is fer |
| 174: | | pain for (X) |
| 175: | PAT: | **what I do with the prescriptions?** |
| 176: | ATT: | excuse me? |
| 177: | PAT: | **what do I do with the prescriptions take em to the ah pharmacy?** |
| 178: | ATT: | correct where do you get your medication |
| 179: | PAT: | **whatchyou increasing now? whatchyou increasing?** |
| 180: | ATT: | the Gabapentin that you're on already they started you on a s- on a small |
| 181: | | dose of a hundred milligrams |
| 182: | PAT: | [to what? |
| 183: | PAT: | [okay fer what |
| 184: | ATT: | fur your burning pain |
| 185: | PAT: | okay I take Gabapentin already at uh one hundred milligrams |
| 186: | ATT: | correct |
| 187: | PAT: | **so why you increasin it?** |
| 188: | ATT: | because you said you wanted better control of your pain |
| 189: | PAT: | [okay |
| 190: | ATT: | right? |
| 191: | PAT: | **fer how (five) how many uh how much uh Gabapentin (XX)** |
| 192: | ATT: | [(XXX) three |
| 193: | | times a day |
| 194: | PAT: | **uh?** |
| 195: | ATT: | hundred milligrams three times a day |

In lines 156-158 the attending physician makes her recommendation to conduct a nerve study and also increase the dose of his pain medication (*we'll increase the dose of your medication pain medication*).  Upon making this recommendation, we see thereafter that the patient is largely absent (lines 160-171).  This absence and lack of acknowledgement on the patient's part is likely due to the way the attending physician's recommendation is structured.  Initially, the attending physician's treatment recommendation formulation is directed to the patient (this is made clear by her pronoun usage), however as she winds down her turn, her talk becomes more technical in nature (*we have to be careful with the by the way with the kidney*).  With this

technical turn the frame shifts, the IMG resident becomes engaged, and she and the attending physician spend the next several turns discussing medication dosage.  This discussion winds down in line 171 and in line 172 the attending physician begins to engage the patient once again with a pre-closing remark (*so stay right here we'll give you those prescriptions okay*) and a reformulation of her original treatment advice (*we'll give you we'll increase the dose of this medication that is fer pain*).  With his first opportunity to provide a response, the patient uses it to ask a question – *what I do with the prescriptions?*.  His question is used either to request additional information (Maynard, 1989) or to seek clarification about what he is supposed to do with the prescriptions.  After the attending physician either mishears or misunderstands his question he reformulates it and adds his own supposition in line 177 (*what do I do with the prescriptions take em to the ah pharmacy?*) to which the attending physician agrees on line 178.

In the subsequent stretch of talk, starting on line 179, the patient and attending physician use a series of question-answer sequences to address the treatment recommendation to increase the Gabapentin dosage.  Unlike the question-answer sequences commonly found in physician-patient interactions in which the physician asks the question and the patient provides the answer (Heritage & Clayman, 2010; Heritage & Robinson, 2006; Robinson, 2003), in this stretch of talk the patient asks the questions and the attending physician answers.  In line 179 the patient, finally acknowledging the recommended dosage increase (22 lines after the initial recommendation), utilizes a repetitively formulated *wh*-question to ask what medication is being increased (*whatchyou increasing now? whatchyou increasing?*).  The attending physician answers the Gabapentin to which the patient overlaps with additional questions *to what* and *okay fer what* in lines 182 and 183, respectively.  In line 185 he continues his line of questioning, using another *wh*-inquiry, to ask why the medication is being increased (*so why you increasin it?*).  With her

answer the attending physician projects the reasoning back to the patient as she states: *because you said you wanted better control of your pain*. The patient provides the agreement token *okay* in line 189 to this justification. In line 191 the patient asks his final question – *how many uh how much uh Gabapentin (XX)* to seek additional information about dosage. The attending physician answers (lines 192-193) to which the patient provides a clarifying *uh?* (line 194), and the attending physician restates the new recommended dosage and frequency (line 195). With this last question, the series of question-answer sequences ends. Thereafter, there is a brief exchange between patient and attending physician about his current Gabapentin prescription and the medical encounter interaction closes (interaction not shown here).

In the post-medical encounter survey the patient provided the answer *going to increase my medication* to question four asking to describe the treatment recommended. Though the medication being increased goes unnamed the patient's survey response coincides with the treatment recommendation provided during both the solo and joint interactions. In response to question nine asking how likely he is willing to follow the treatment recommendation, the patient answered *very likely* to follow the recommendation. Consequently, given this *very likely* response it appears probably that the patient will follow the recommendation to increase his dose of Gabapentin.

Taken together, the interaction and survey data show alignment between the treatment advice given during the medical encounter interaction, the patient's survey response and his likelihood to follow the recommendation. The revealing feature of this example remains the way in which the treatment advice sequences unfolded in the interaction, specifically the patient's use of questions. His utilization of a series of *wh-* inquiries serves dual purposes: the questions seek answers to medical-related questions and they index active patient participation. In the next

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example we also see how the patient uses interrogatives to seek medical information and

participate in the treatment. In addition, we will see how her questions are used to cause medical

authority to vacillate back and forth between her and the IMG resident.

The second example in this section also occurs in the Neurology clinic with a new patient

who is presenting with headaches. The patient, a female, is taking medications for other

conditions but she is presently not on any medication to treat her headaches. The IMG resident

and patient move into the sequence presented below as the physical exam is completed:

Extract 4.31 NESG004 Headache No diagnosis (Solo interaction)
```
62:     RES:   alright hang in here I'm gonna go talk to my attending and come back now
63:            ho- now (0.5) what do you want us to do with your headache do you want
64:            to get to start a new medication or are you happy with how your headache
65:            is er what do you want to do?
66:     PAT:   I don't know you're all the doctor ya'll got to tell me I have no I have
67:            no earthly idea what is going on
68:     RES:                                                              [how (X)
69:     RES:   okay
70:     PAT:   ya'll are the specialists so that's why I'm here
71:     RES:   [how                          [how how bad is your headache how much is it
72:            bothering you
73:     PAT:   well I I really can't say now right now I have a headache I guess cuz cuz
74:            that light was so bright in my eyes
(Brief discussion about how headache does or does not affect patient's daily activities)
81:     RES:   that's what I'm asking because it's well controlled do you want to start a
82:            medication now er do you
83:     PAT:                  [what kind of medication
84:     RES:   the medication what I'm thinking is uhm called Doxepin it's a medication
85:            that you have to take everyday regardless you have a headache or not and
86:            it will prevent the future headaches from coming on
87:     PAT:   I'm sayin I'm gonna be (1.0) I mean I'm gonna be ah dependent upon
88:            this medicine everyday?
89:     RES:   well you'll not be depending dependent on it=
90:     PAT:   =for how long? because you know I really like this this pain is (1.0)
91:            but I I don't take the pain because I don't wanna be dependent upon
92:            you know what I'm sayin=
93:     RES:   =it's it's not a pain medication it's not one of those medications like
94:            Morphine or Oxycodone that will make you dependent on but this
95:            medication you probably had to take for a couple month like a few months
96:            or a few years couple years and see and maybe at that ah after that we can
97:            try to decrease that and see if your headaches come back or not…
```

Similar to the patient-centered approach presented in Extract 4.27 above, the IMG resident commences the treatment advice sequence with a solicitation to the patient asking for her input about treatment for her headache going forward. However, as will be shown below, the patient's answer in response to the solicitation lies in sharp contrast to the way the patient responded in Extract 4.27. The IMG resident's solicitation in lines 62-65 contains multiple interrogatives with the upshot being what she would like to do treatment-wise with her headache. The IMG resident's solicitation appears to backfire as he receives a stinging response from the patient in line 66. The patient refuses to participate in this patient-centered approach and provide an opinion about whether she wants treatment for her headache or not. Instead, she relinquishes the agency proffered through the IMG resident's interrogatives and prefers to maintain the identity of the archetypal patient acquiescing to the medical expert to tell her what needs to be done. The patient maintains this stance as she states *ya'll are the specialists so that's why I'm here* in line 70.[23]

The IMG resident proceeds with a series of additional questions: asking the patient how bad her headache is, if it affects her daily activities, and he attempts once again to ask her if she wants to start a medication now in lines 81-82. In response to this last question the patient answers with a question of her own *what kind of medication* in line 83. With this information-seeking question, the patient nudges the IMG resident into the medical expert role, compelling him to provide the technical knowledge she was seeking in lines 66-67 and 70. He obliges in lines 84-86 by answering the patient's question and naming the medication (Doxepin) he was considering. In response to this treatment recommendation the patient asks an additional question *I'm gonna be ah dependent upon this medicine everyday?*. With this question she is

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[23] This conflictual interaction will be reexamined in the following section in research question four, which explores the ways in which relational work is used to manage (im)politeness.

seeking medical information about how Doxepin works in her system and whether chemical

dependency is an issue with this type of medication. The patient follows this question with

another medically-related question *for how long?* in line 90 seeking to know how long she would

have to take Doxepin and reiterating her dependency concern. Starting on line 93 the IMG

resident provides the medical information necessary to answer her question and with this the

treatment advice sequence winds down.

Turning to the interaction between the patient, IMG resident, and attending physician, in

this medical encounter the joint interaction is brief. The attending physician recommends they

order an MRI and he also states *we need to getchyou on some medication* on line 138 below.

Extract 4.32 NESG004 Headache No diagnosis (Joint interaction)
```
138:   ATT:   but we need to getchyou on some medication ta try to keep these from
139:          happening an we gotta s- reduce the amount of pain medicine you're on or
140:          we'll never getchyou any relief not necessarily stop it totally but we gotta
141:          reduce it so the first thing we wanna do is we wanna do an MRI scan of
142:          the brain if that's normal then we'll talk some more about where we go
143:          from there but first we need to know that
144:   PAT:   mkay
145:   ATT:   okay? alright good luck
146:   PAT:   thank you sir
```

In response to the attending physician's extended turn, the patient provides the minimal response

token *mkay* in line 144 acknowledging the information received. With a rising intonation *okay* in

line 145 the attending physician pursues patient agreement but provides no room for her to

respond as he continues to hold the floor with *alright good luck*. Once his turn is completed, she

responds with a polite *thank you sir* and with this response the joint interaction closes down and

the attending physician leaves the examination room. At this point, it seem reasonably clear then

that the patient is to only get the MRI completed. Neither medication recommended during the

solo or joint interaction is mentioned again by any of the participants.

Approximately 20 lines later (20 lines not displayed here) the patient utilizes a question to reopen the topic of medication and asks in line 165 below *so ya'll startin me on that medicine?*.[24] The placement and function of this question appears to wrest medical authority away from the physicians as it reopens the mediation topic.

| | | |
|---|---|---|
| 165: | PAT: | **so ya'll startin me on that medicine?**[25] |
| 166: | RES: | if you want to yes (1.0) do you want to? |
| 167: | PAT: | so wh- what did he say if I'm not gonna have I'm gonna like jus- add it to |
| 168: | | it with that= |
| 169: | RES: | =let's let's get the MRI first an then we'll talk about it when we have the |
| 170: | | MRI okay? |
| 171: | PAT: | ⎡okay |
| 172: | RES: | do you wanna start it now? |
| 173: | PAT: | **(XX) ya'll g- ya'll g- ya'll gonna do it at my watchacallit could ya'll** |
| 174: | | **send it to my pharmacy?** |
| 175: | RES: | the medication yeah |
| 176: | PAT: | mkay I can pick it up later on |
| 177: | RES: | you wanna start the medication |
| 178: | PAT: | **every it can help it can't do noth- it can't hurt it can't do nothing but** |
| 179: | | **really help anyway so** |
| 180: | RES: | okay we'll start you on ah the medication then okay? I'll put it into the |
| 181: | | system hang in her fer a second more an we'll let you go |

Besides reopening the topic of medication, what else does this question do? First, it appears to "muddy" or creates conflict with the recommended treatment plan. In other words, subsequent negotiation now needs to take place on a topic that appeared to be closed approximately 20 turns ago. Secondly, the question may serve to clear up confusion the patient may have about the treatment plan. That is to say, due to the fact the IMG resident and attending physician made different treatment recommendations, from the patient's perspective she may have genuine confusion about whether medication is being prescribed now or not. With this question she seeks clarity on the medication matter. Thirdly, with this question the patient puts the IMG

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[24] The medical encounter returns to a solo interaction between the IMG resident and patient due to the fact the attending physician has left the examination room.
[25] With the patient's use of a vague referential, *that medicine*, it is unclear whether she is referring to the medication discussed during the solo or the joint interaction.

resident in a risky position on both a medical and interactional level.  On the medical level, as

previously mentioned, the question reopens a medical topic already considered closed.

Consequently, in now having to readdress the topic of medication, without the attending

physician present, leaves the decision-making process in the IMG's hands.[26]  At the interactional

and pragmatic level, this non-redressed question clearly threatens the IMG resident's face.  Thus,

given their previous contentious conversation this question puts the IMG resident and his

subsequent response in a delicate light.

Turning to his response, in line 166 the IMG resident says *if you want to yes (1.0) do you*

*want to?*.  With this response the IMG resident deflects the medical authority placed squarely on

his shoulders and cedes it to the patient.  He tries to regain the authority and close down the

medication discussion in lines 169-170 as he re-proposes the original treatment plan decided

during the joint interaction to just get the MRI.  With the use of the tag question *okay?*, the IMG

resident seeks the patient's input and acceptance of this plan.  She accepts this plan through a

latched turn in line 171 (*okay*).  However, the IMG resident keeps the medication talk alive and

returns the decision-making to the patient as he asks her again in line 172 if she wants to start the

medication (*do you wanna start it now?*).  The patient does not respond directly in the next turn,

instead she utilizes a question of her own to determine if they could send the medication to her

pharmacy (lines 173-174).  In line 177 the IMG resident uses repetition to confirm one last time

that indeed the patient wants to start the medication now (*you wanna start the medication*).  She

answers affirmatively stating that starting the medication *can't hurt it can't do nothing but really*

*help anyway*.  The IMG resident accepts this response in the following turn and with this the

negotiation ends and the decision is made to add the medication to her treatment plan.

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[26] In a teaching environment such as this one, the attending physician bears ultimate legal and financial
responsibility.  Thus, medical authority and responsibility lies squarely with the supervising attending physician.
Given this, a modification to the treatment plan would require sign off by the attending physician.

This patient completed the post-medical encounter survey. The patient answered *headache medicine and MRI* to question four asking to describe the treatment recommended. Her answer of an unnamed medication is unsurprising given the vague medication references used throughout the latter stages of the interaction (*some medication*, line 138; *that medicine*, line 165; *the medication*, line 177 and 180). In response to question nine asking how likely she is willing to follow the treatment recommendation, the patient answered *likely* to follow the recommendation. Consequently, these interactional and survey data appear to indicate that the patient will follow the recommendation to get the MRI completed and take the headache medication.

Research on patient questioning in the medical encounter reveals that while patients do ask questions they do so rarely (Pahal & Li, 2006; Roter, 1984; West & Frankel, 1991). In her research Roter (1984) provided some explanations for the lack of patient questioning. It may be because patients did not want to be perceived as "bothering" the physician with too many questions, physicians may have signaled, through the use of nonverbal cues, that patient questioning is discouraged, or physicians may have answered the patient's question before they had an opportunity to ask (p 403). However, when patients do ask questions during medical encounters, they are used to seek information or clarification (Street & Millay, 2001) and they tend to fall into two broad categories: questions of a medical nature or administrative questions (Zhang, 2010). Additionally, Zhang (2010) showed that patients' initiation of questions were either 'occasioned' through the prior turns of talk or self-motivated (p. 260) and Silverman, Peräkylä, and Bor (1992) showed that patients tended to engage in questioning when invited by the practitioner (p. 80). As presented in this section, in addition to patients' use of clarification questions, these data provided several examples in which patient questions were utilized to seek

information on both medical and administrative issues.  We saw how patients' questions, following Zhang's (2010) results, were 'occasioned' by prior turns of physicians' medical talk. Additionally, we saw an example (Extract 4.30) in which the patient assumed the questioner role in a series of question-answer adjacency pairs used to seek answers to his medication-related questions.  Most patient questions in these data were 'occasioned'; however, one patient's question of a self-motivated nature (using Zhang's term) precipitated further treatment discussion and a modification to the patient's treatment plan (Extract 4.32).  Consequently, these patients' pursuit of clarification, information, and the redirection of conversation through the use of questions in the treatment advice phase serve as exceptional examples as compared to the physician-patient interactional norm and, as such, demonstrate how the treatment advice phase can jointly unfold utilizing this non-normative discourse approach.

**Conclusion.**

In this section the patient and their responses to treatment advice received primary attention.  I utilized data from three sources – solo interactions, joint interactions, and patient survey data – to triangulate my analysis and interpretations of their responses to treatment and attempted to determine the patients' expressed likelihood of following the treatment advice.  In this section I highlighted four different response types patients provided while in interaction with their physicians.  My analysis presented the jointly constructed nature of the treatment advice discourse and also demonstrated how each response type served different functions during the course of the interactions.

The first example presented in this section suggested that the patient's responses indicated an ambivalence toward the future treatment plan.  The patient's topic change and minimal use of acknowledgement tokens during treatment recommendation discussions created

uncertainty about her willingness to follow the recommended course of treatment (increase Plaquenil dosage) in the future. And while both the IMG resident and attending physician utilized various strategies in an attempt to convince the patient to follow their recommendation (i.e., patient education, simplified medication administration), a vigorous attempt was not made to pursue the patient's acceptance. The patient's self-reported data provided some indication of her willingness to follow the treatment advice but in this case additional follow-up or longitudinal data would be beneficial in determining if the patient indeed modified the medication dosage. In fact, some of the patient's ambivalence displayed during this medical encounter may have to do with the fact that she is already taking the medication under discussion. In this sense she is already a compliant patient taking the prescribed medication. At issue, however, is the medication dosage and not a more critical matter about whether she should start or stop a medication. Consequently, this seemingly minor dosage issue may in part contribute to her ambivalence.

The second type of response I explored in this section was patients' display of agreement with treatment recommendations. I showed two examples in which the patients utilized minimal responses (e.g., *mkay*, *okay*, *alright*) to acknowledge and accept the physicians' treatment advice. In addition, one example displayed the patient's use of an expanded engagement response (*okay that sounds great yeah*) indexing an agreeable and compliant patient willing to follow the proposed course of treatment. These displays of acceptance are in line with previous research that has explored the treatment advice phase showing that both physicians and patients align to and pursue agreement (or rejection) before closing this phase of the medical encounter (Koenig, 2008, Stivers, 2006).

A third response type is solicited treatment recommendations. In this dataset there are several opportunities for the patients to provide their own treatment recommendation rather than respond to it. In these instances the physician opens up the treatment advice phase with a solicitation for patient input and a concomitant opportunity to participate in the decision-making process about their future course of treatment.

A growing body of literature exists exploring the important topic of patient participation in medical encounters (see Collins, Britten, Ruusuvuori & Thompson, 2007 for an overview). However, despite this body of research scant empirical evidence exists on this type of patient-solicited response during the treatment advice phase. To begin to provide some evidence and insights into the different linguistic and discursive strategies patients use to respond to these solicitations I presented two contrasting examples. In the first example (Extract 4.27) the patient accepted the opportunity, becoming an active agent in telling the IMG resident what she would like to do with her treatment going forward. In comparison, a second example (Extract 4.31) showed a patient who resisted the IMG resident's invitation to participate in the treatment decision. Given these opposing responses then the ensuing conversation about treatment took different trajectories with varying levels of negotiation required to settle on a treatment decision. As a consequence and despite the call for a more patient-centered approach during medical encounters, these two contrasting examples of patient-solicited input can serve as instructive examples for physicians, especially where treatment decisions are concerned.

The final response type is patients' use of interrogatives, which research demonstrates occurs infrequently during medical encounters. These data demonstrated that the forms and functions of patients' interrogatives were realized in different ways. In many instances, patients' questions functioned to clarify physicians' previous statements or to seek additional information

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about medical, specifically about the recommended medication, or other administrative issues. In this way, the questions served to demonstrate the patient's active participation in the ensuing conversation and to provide the patient with the knowledge needed to formulate an informed decision about the treatment recommendation. Additionally, in one example the question-answer adjacency pair sequence between patient and attending physician was realized using a non-normative format. Moreover, another example had an implicit effect on medical authority as the import of some of the patient's questions served to create a "push and pull" effect on authority as it passed back and forth between the patient and IMG resident. Thus, these different examples add to the extant body of literature on the use of patient interrogatives in the medical encounter in general and in specific the treatment advice phase.

In the previous three sections I examined the structure and organization of the treatment advice phase and the ways in which physicians and patients negotiate and co-construct treatment advice. In the last section of Chapter four I explore the discourse strategies physicians and patients use to co-construct, manage, and maintain the relational side of their interactions.

**Research Question Four**

In what ways is relational work used to manage (im)politeness in IMG resident-patient interactions?

As examined in Chapter two and as demonstrated by the interactions in this dataset, physician-patient interactions fall into a fuzzy category straddling the boundary between institutional discourse and everyday conversation. It goes without saying that physicians must attend to the institutional goals of diagnosing, treating, and caring for patients but attaining this end goal without attending to the relational side may become problematic, as Ruusuvuori (2007) points out, if the institutional task deals with physical and mental issues (p. 598). In other words,

health and wellbeing issues require dual attention on the individual with the ailment and the ailment itself.  Therefore, attending to both the institutional goals and tasks and the interpersonal side of the relationship becomes a balancing act for physicians.  With the three previous research questions I have focused on and analyzed the discourse strategies used to attend to the institutional task of giving and receiving treatment.  In this last research question I turn to the relational side of the interaction to examine the discourse strategies IMG residents and patients utilize to co-construct, manage, and maintain interpersonal aspects of their relationship.

To review from Chapter two, the approach I use to analyze the physician-patient relationship is termed "relational work".  Relational work is a contemporary approach closely tied to research on politeness and can be described as the work individuals invest in negotiating interpersonal relationships with others (Locher & Watts, 2005, 2008).  Relational work entails what Watts (2003) and Locher and Watts (2005, 2008) term the discursive approach to politeness due to the fact it takes into account both the speaker and the hearer in interaction and the effects their linguistic choices have on the interlocutors' relationship.

Taking a relational work approach entails moving away from viewing language or behavior as either polite or impolite; in other words, language or behavior should not be viewed solely in this dichotomous way.  Within a relational work approach, language can run the gamut from impolite or rude to appropriate to polite or even affectionate.  Moreover, due to the fact relational work relies on the concept of face to aid understanding of the dynamic nature of relationship construction, the terms face-enhancing, face-maintaining, and face-challenging have been proposed (cf. Arundale, 2010; Tracy, 1990).  These are second-order or theoretical terms that have been proposed and used in an effort to describe the effects linguistic choices have on interactants in a specific social context.  For instance, a face-challenging utterance is "one that is

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*treated as such* by interactants in a given social context" (Miller, 2013, p. 75, italics in the original). The same face-challenging utterance used in a different social context may not be received as face-challenging but rather as face-maintaining or even face-enhancing. Throughout this section I will attempt to use these terms – face-enhancing, face-maintaining, and face-challenging – as I analyze the varied discourse strategies the IMG residents and patients use to manage the interpersonal side of their interaction in the medical encounter.

During the analysis process in which I examined, categorized, and analyzed "acts" of relational work in the dataset, a necessary step of the process was to consider the goal or purpose of the particular utterance in the interaction. To aid in this analysis, I drew a distinction between discourse types. [27] Kasper (1990) tells us there are two discourse types "that bear on the quality and quantity of politeness" (p. 205). These two discourse types are interactional and transactional. Interactional[28] discourse "has as its primary goal the establishment and maintenance of social relationships" and transactional discourse focuses on the optimally efficient transmission of information" (Kasper, 1990, p. 205).

Holmes and Marra (2004) examined the interpersonal and transactional goals achieved through the use of various relational practices (e.g., small talk, humor, softening refusals, hedging directives) in multiple workplace settings. Following this approach, as physician-patient interactions lie somewhere along the continuum between strictly institutional talk or strictly ordinary conversation (Ainsworth-Vaughn, 2001; Heritage & Clayman, 2010) it is both useful and essential to consider both the interpersonal and transactional goals of the medical encounter. In other words, it can be argued that physician-patient interactions contain salient discourse

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[27] I consider discourse types to be similar conceptually to Levinson's (1992) activity types discussed in Chapter two and which serve as one of the theoretical underpinnings of the study.
[28] I prefer the term "interpersonal" so as not to confuse it with the use and meaning of interaction used differently in this paper. Hereafter, I will use the term "interpersonal" in lieu of "interactional".

features serving both interpersonal and transactional goals or functions. Consequently, examining relational work acts using these two discourse activity types became a practical and useful classification approach during my analysis.

Table 7 displays the different types of relational work that I found in the 28 interactions in the dataset. The table displays the function, which participant used the function, in which phase the function occurred, and the goal of the function (interpersonal, transactional, or both). As evinced by the data in the table, I identified 17 occurrences of relational work, ranging from humor and small talk to managing complaints, resistance, and conflict. The data revealed that all interlocutors, the patient, IMG resident, attending physician, and patient's advocate participated in relational work. However, the data also revealed that only some participants utilized some of the relational functions. For instance, only one attending physician used teasing to establish interpersonal relations and only one patient initiated the telling of short stories during the treatment advice phase. Moreover, it stands to reason that some of the relational functions are appropriate for only one type of participant. In other words, it is highly likely only the physician, either IMG resident or attending physician, would deliver patient education and only the patient would express resistance. These data demonstrated that relational work functions were found throughout all phases of the medical encounter. I did not limit analysis for this research question to the treatment advice phase only; rather, I examined the entire transcript for occurrences of relational work. Finally, the dataset revealed that discourse was used to achieve both interpersonal and transactional goals; in some instances the relational work functioned to achieve both goals simultaneously.

Table 7

*Relational Work by Function*

| Function | Participant who used function | Phase in which function is used | Goal |
|---|---|---|---|
| Deliver patient education | Attending physician IMG resident | History taking phase Treatment advice phase Closing phase | Interpersonal and Transactional |
| Express concern | IMG resident Patient | Opening phase History taking phase Treatment advice phase Closing phase | Interpersonal and Transactional |
| Express empathy | Attending physician IMG resident | History taking phase Treatment advice phase | Interpersonal |
| Express honesty | Attending physician IMG resident | Treatment advice phase Closing phase | Transactional |
| Express optimism | Attending physician IMG resident Patient | Opening phase History taking phase Treatment advice phase Closing phase | Interpersonal |
| Express reassurance | Attending physician | History taking phase | Interpersonal |
| Express resistance | Patient | Opening phase Treatment advice phase | Transactional |
| Express surprise | Attending physician IMG resident | History taking phase | Interpersonal |
| Humor | Attending physician IMG resident Patient | Opening phase History taking phase Treatment advice phase Closing phase | Interpersonal and Transactional |
| Manage complaints | Attending physician IMG resident | History taking phase Treatment advice phase | Transactional |
| Manage conflict | IMG resident | Treatment advice phase | Transactional |
| Sarcasm | Patient | History taking phase | Interpersonal |
| Short stories | Patient | Treatment advice phase | Interpersonal |
| Small talk | Attending physician Patient Nurse | History taking phase Treatment advice phase Closing phase | Interpersonal |
| Take stance against prescribing certain class of medication | Attending physician | Opening phase | Transactional |

Table 7 (Continued)

| Teasing | Attending physician | Opening phase<br>History taking phase<br>Treatment advice phase | Interpersonal |
|---|---|---|---|
| Use terms of endearment | Attending physician<br>IMG resident | Opening phase<br>History taking phase<br>Closing phase | Interpersonal |

In the section that follows I show the analysis of several examples to illustrate the discourse strategies the participants used to manage relations and achieve interpersonal and transactional goals during the medical encounter. As Table 7 demonstrates there were several displays of relational work in these data amongst all the participants. Consequently, I illustrate relational work in action from nine different functions. Except for a few examples that occur during the joint interaction and include the attending physician, given the focus of the study, the majority of the interactions I selected illustrate relational work between IMG residents and patients.

**Humor.**

The data revealed that humor can be utilized by both physicians and patients in an effort to lightening the atmosphere and maintain harmonious relations during medical encounter interactions. Examples of humor were found throughout each of the phases of the medical encounter demonstrating its versatility as an affiliative discourse resource (Zayts & Schnurr, 2011). For instance, in these data physicians used teasing remarks with their patients as an interpersonal strategy to establish rapport. Physicians teased their patients about their food and beverage consumption, about the ability to correctly pronounce an IMG resident's name, and about a patient's patience level. Moreover, one attending physician-IMG resident duo utilized teasing as a strategy to maintain collegial relations with one another. The data also revealed that

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patients used humor in some instances to verbalize self-evaluations of their physical condition and abilities.

Exploring an example of humor in greater detail, the interaction displayed below occurs during the joint interaction with a female patient diagnosed with psoriatic arthritis. This treatment advice interaction was previously examined in research question one to demonstrate how each participant assumed their institutional role to co-construct the treatment advice phase. The interactants have had an opportunity to establish rapport previously, as this is a follow-up visit for the patient. Extract 4.33 below takes place after the treatment decision was made to prescribe Arava for the patient's psoriatic arthritis. The prescribed medication Arava should not be taken if the patient plans to become pregnant or is pregnant because it may cause harm to the fetus. Consequently, the attending physician and IMG resident want to ensure the patient has no intentions of becoming pregnant.

Extract 4.33 RHCG007 Psoriatic arthritis

| 377: | FEL: | again after their partners get vasectomies so if you suspect at any point |
| 378: | | that you are pregnant |
| 379: | ATT: | [mm |
| 380: | FEL: | uhm:: don't take the medica- |
| 381: | PAT: | [uh I'm also on birth control for headaches so if I get pregnant it's |
| 382: | | like |
| 383: | ATT: | okay |
| 384: | FEL: | [on birth control for headaches? what (do you mean) |
| 385: | PAT: | yeah my hormo-if I don't keep my hormones level I get horrible |
| 386: | | headaches yeah |
| 387: | ATT: | [mm |
| 388: | FEL: | [oh okay |
| 389: | FEL: | alright |
| 390: | ATT: | okay |
| 391: | PAT: | **so if I get pregnant it's like the second coming** ((PAT and ATT laugh)) |
| 392: | ATT: | [okay |
| 393: | FEL: | alright (0.5) okay |

During this and previous stretches of talk, the patient makes it known that adequate contraceptive measures (vasectomy and birth control pills) have been taken to help ensure she does not become

pregnant. The patient's first attempt at humor is made in line 381 but she is not allowed to finish her thought as both the attending physician and IMG resident interrupt her. After the explanation and acceptance of the patient's birth control use in lines 384-390, the patient repeats her original remark *so if I get pregnant it's like the second coming*, provoking laughter from both the attending physician and herself. With this account the patient affirms her position that becoming pregnant is inconceivable given the precautionary measures her husband and her have taken and adds a dose of humor to convey this conviction.

What does this humor do during this interactional sequence? The humor serves an interpersonal function and it also functions on a transactional level in two consequential ways. It directly addresses and shuts down the discussion about pregnancy in a humorous way. Meanwhile, it diffuses the physicians' talk and understandable concern about pregnancy while taking Arava. Aligning with Ruusuvuori's (2007) study on displays of empathy in medical encounters, this example shows how humor serves both interpersonal and transactional functions and in this case brings the pregnancy sequence to a close. As regard the relational work this humorous remark performs, it may be categorized as face-enhancing as the patient positions herself as having a sense of humor. Having a sense of humor is not a requirement of this type of interaction, consequently the patient's humorous quip works to enhance the relations between her and her physicians.

There are times, however, when attempts at humor do not go as planned. In Extract 4.34 below the IMG is wrapping up the medical encounter, asking the patient if she has any questions

or additional concerns she wants to discuss.[29]  The IMG resident and patient have met at least

once before as this is a follow-up visit with this patient.

Extract 4.34 NESG001 Headache
80:     RES:    any other questions you have for me
81:     PAT:    mm::: nope
82:     RES:    any concerns
83:     PAT:    mm::: nope ((PAT laughs))
84:     RES:    **dirty looks**
85:     PAT:    what'd you say
86:     RES:    dirty looks
87:     PAT:    uh uh no ((RES laughs))
88:     RES:    alright

During this standard wrap-up, the IMG resident asks an unorthodox question in line 84 as a part

of the sequence and in an attempt to add humor or lighten the mood of the encounter.  However,

it appears that his attempt at humor backfires as the patient asks in line 85 *what'd you say*.  With

her question, the IMG resident is obliged to repeat his inquiry, thus negating the question's

humorous effect.  It is possible the patient was not anticipating this type of question during the

closing sequence, especially delivered from an L2 user of English.  Moreover, *dirty looks* used in

this way is an expression one would not expect in this context in American culture.  Any or all of

these explanations could have contributed to this failed attempt at humor.[30]

    In this example, the IMG resident's attempt at humor served as a face-challenging move

on two fronts.  First, it can be argued that the IMG resident threatened his own face in this failed

attempt at humor.  Additionally, in light of the IMG resident's intended use of the term *dirty*

*looks* to index a dissatisfied patient may serve as a challenge to the patient's face given its more

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[29] In this medical encounter the attending physician does not come into the examination room to participate in the interaction.  Instead, the IMG resident confers with the attending physician outside of the exam room and then returns to inform the patient of the "no treatment" decision.

[30] In communication with this IMG resident about the use of *dirty looks*, he indicated its intended meaning was in association with a dissatisfied patient, as in a dissatisfied patient who produces a scowl or sour expression. Although he did not note remembering (nor do I remember from my observation of the medical encounter), it is possible the patient's facial expression revealed some dissatisfaction perhaps due to the fact treatment for her headache was not forthcoming or for some other reason.  He also indicated that after this interaction he stopped using this *dirty looks* expression during medical encounters.

contestive, as opposed to supportive, type of humor (Holmes & Marra, 2002). All things considered, this example demonstrates a marked use of humor in the medical encounter.

Both examples served as exemplars of the style of humor found in this dataset. That is to say, single humorous contributions from one participant, as opposed to extended sequences of humor involving several participants, were far more prevalent in these data. As demonstrated, the patient's use of *so if I get pregnant it's like the second coming* and IMG resident's use of *dirty looks* served as one-off quips or (almost) witty one-liners (Holmes & Marra, 2002, p. 1689), which contributed to the unfolding of the medical discourse. It comes as little surprise that this style of humor as opposed to a more collaborative style was found more frequently in these physician-patient interactions given the many social factors (e.g., time constraints, power differential, task-orientation) that serve as limitations on relationship development in the medical encounter.

**Sarcasm.**

Another type of humorous function used to co-construct and maintain relations in the medical encounter is sarcasm. This example comes from an interaction with a new patient who was referred to the Rheumatology group for a second opinion on her lupus diagnosis. This part of the interaction takes place during the joint interaction, after the attending has joined the examination. Moreover, it is another example, as demonstrated in research question one, demonstrating how interactions, even as brief as Extract 4.35 below, get co-constructed through multi-party talk. Multiple individuals, the attending physician, patient, IMG resident, and patient's mother take turns constructing the talk.

Extract 4.35 RHCG004 Undiagnosed
251:   ATT:          okay how's your concentration?
252:   PAT:          **what concentration**
253:   ATT:          like uhm

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| 254: | FEL: | no she's she being uh |
| 255: | PAT: | I'm sarcastic |
| 256: | PAT MOT: | she's been sarcastic |
| 257: | FEL: | she has a huge concentration memory problem |
| 258: | PAT: | yes (XX) |
| 259: | PAT MOT: | she does lately |

This almost cliché example of sarcasm by the patient in line 252 works to lighten the mood and provide a welcome break in the attending physician's questions about her symptoms and general health issues (data not shown).  It is clear the attending physician does not pick up on her sarcastic remark as it appears in line 253 that he begins to provide an additional description or explanation of his question.  This lack of awareness may be because the attending physician also uses English as his second language; consequently, the patient's use of sarcasm, her tone, or placement of this sarcastic remark may be unexpected or unfamiliar to him.  Noticing the lack of uptake, the IMG resident begins to explicate the intent of the patient's response – *no she's she being uh* – but the patient herself disrupts the IMG resident's explanation.  The patient takes a different approach and directly states the function of her response – *I'm sarcastic*, which is echoed by the patient's mother in line 256.  After attending to the patient's sarcasm in this sequence it is actually the IMG resident who answers the attending physician's concentration question in line 257 and the patient's mother agrees in line 258 that the patient has *a huge concentration memory problem*.  The attending physician does not directly address the sarcasm and instead returns to his history-taking line of questioning (data not shown).

The attending physician's initial question:  *how's your concentration?* could certainly be considered a challenge to the patient's face.  However, to argue that this is a face-challenging question within a medical context focused on physical and mental health might be considered dubious analysis.  Taking a discursive approach to relational work analysis requires an examination of the patient's response.  In response to what most would consider an embarrassing

question about concentration, the patient uses ironic humor, which works to diffuse the face

challenge. Thus, with this use of sarcasm it is apparent the patient reads the question as a face

challenge and uses a discourse strategy (sarcasm) to preserve her face and mitigate the challenge.

Additionally, the IMG resident's explanation to the attending physician may also be considered

face challenging as it explicitly assumes the attending physician does not understand the

patient's sarcastic, self-deprecating comment. It is a risky move because the attending physician

holds a more senior role than the IMG resident. However, her risk is mitigated when her

explanatory turn is cut short by the patient who ends up providing the explanation herself. In

general, self-deprecating remarks provide social cohesion among interlocutors (Holmes &

Stubbe, 2003). In support of this argument, this example demonstrates how social cohesion is

reinforced through the joint construction of the sarcasm sequence amongst the four interlocutors.

Thus, this example demonstrates how sarcasm was used to provide a humorous respite during a

string of history-taking questions and to deflect the weight of the attending physician's question.

Despite the multiple challenges to face, discourse strategies (e.g., self-deprecation, overlapping

talk) were used to lessen the threats, jointly construct the sequence and provide an answer to the

attending physician's question.

**Small talk.**

Within different institutional settings, such as medical encounters, small talk serves

chiefly as a social function. It functions to construct, maintain, and sustain collegiality between

colleagues and provides a counter balance or welcome respite to the task-oriented talk associated

with the institution or workplace and is what Holmes and Stubbe (2003) call "oiling the

interpersonal wheels" (p. 98). In these data small talk did not occur frequently within the

medical encounter. I found instances of small talk in only two of 28 interactions. However,

within these two medical encounters the amount of time devoted to small talk and the variety of topics covered was considerable. The small talk topics covered by the interactants in these medical encounters included: patient's family members, pets, movies, and patient's hobbies. In these instances, small talk was initiated by the attending physician, patient, and nurse. In no instances did IMG residents initiate small talk. In Jain and Krieger's (2011) study the IMG resident participants had considerable difficulty initiating and participating in small talk with their patients and noted that while small talk can be a useful convergence communication strategy to utilize with patients it oftentimes worked as a divergence strategy (p. 101). While this finding may or may not align with the reasons no IMG resident in this study initiated small talk it does highlight the fact that some relational moves entail more risk, especially for IMG residents, than others.

The extract I selected to demonstrate small talk in action comes from a Rheumatology follow-up visit. The small talk in this example occurs between the IMG resident and nurse who accompanies the patient. In previous sections (see "Multi-party talk" in research question one and "Solicited treatment advice" in research question two) we have seen these participants in action as I presented how they jointly constructed the treatment advice phases. In both treatment advice sequences (the solo and joint interactions), the nurse contributes to the unfolding treatment advice talk. Below we see how the nurse utilizes small talk at the boundaries of the treatment advice sequence as a way to attend to the interpersonal side of interaction. The extract occurs immediately following a discussion between the IMG resident and patient about pain medication she is taking. The nurse starts in:

Extract 4.36 RHOI011 Rheumatoid arthritis
102:    NUR:   so are you going to stay in adult rheumatology? or are you going to do
103:            pediatric?
104:    FEL:   oh adult

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105:   NUR:  we (x) need there's not enough pediatric rheumatologists we have one in
106:         this area that's it one
107:   FEL:                                              [I know
108:   FEL:  there are I think no more than one hundred something in the whole
109:         country
110:   NUR:  that's what you should go into there's a shortage
111:   FEL:  (xxxx) ᴼtake a breath thereᴼ
112:   (3.0)
113:   NUR:  I don't blame him I don't think I could deal with kids everyday twenty
114:         four hours a day I love'em but I don't think I could like as a nurse I can't
115:         do peds I did my rotation on the peds floor and pulling my hair out
116:   ((ALL laugh))
```

This initiation of small talk on line 102 occurs after a five second pause. The pause

serves as a convenient opening for the nurse to change topic and initiate this small talk sequence

with the IMG resident. In her opening question, the nurse expresses curiosity about the IMG

resident's plans to continue practicing rheumatology with the adult population or if he has given

consideration to pediatric rheumatology. With this question the nurse attempts to establish an

interpersonal relationship with the IMG resident. Her deftly formulated question stays within the

medical domain (with which population does he want work?) but by asking about the IMG

resident's personal plans her question moves into the personal domain. The IMG resident

answers her question without delay – *oh adult*. Presumably anticipating this answer and perhaps

as a way to get to the IMG resident to reconsider his plan, the nurse provides an evaluation of the

dismal state (due to a lack of physicians) of pediatric rheumatology in the local area. The IMG

resident continues the small talk thread providing his own evaluation of the state of pediatric

rheumatology countrywide, encouraging the nurse to reissue a plea to work with children in line

110. In the next turn the IMG resident momentarily returns the talk to the medical domain,

asking the patient to take a deep breath. A three second pause ensues which is finally filled

when the nurse returns to the small talk topic. In line 113 she issues another evaluation, in this

instance about the IMG resident's decision to work with adults instead of children based on her

own personal experiences.

The nurse's personal and humorous evaluation ends this small talk sequence and talk

turns to treatment advice for the patient.  After the treatment advice sequence closes and the IMG

resident begins to wrap up the solo interaction, the nurse seizes this closing opportunity to

initiate more small talk with the IMG resident.  Holmes and Stubbe (2003) tell us that small talk

is typically, though not exclusively, found at the boundaries of an interaction with opening and

closing phases serving as obvious junctures for this type of talk (p. 90).  The example below

illustrates this point demonstrating how small talk is utilized within the closing phase of a

medical encounter.

```
131:   FEL:   okay I will be back
132:   NUR:   so you're from (FEL's country of origin) and you're studying over here
133:          medical school
134:   FEL:   no
135:   NUR:   [are you from (FEL's country of origin)?
136:   FEL:   I don't I have finished medical sch- yes I'm from (FEL's country of
137:          origin) I have finished medical school I have finished internal medicine
138:          and this is sub-specialty
139:   NUR:   oh so you're gonna stay here in this country or are you gonna go back you
140:          think
141:   FEL:   that's a good question
142:   ((PAT laughs))
143:   NUR:   stay here we need you here ((PAT laughs)) we need more doctors here
```

In line 131 the IMG resident announces *okay I will be back* signaling the end to his examination

and indicating that he and likely the attending physician will return.  In response to this

announcement the nurse introduces a new small talk topic as she inquires about the IMG

resident's country of origin.  The inquiry is similar to her previous small talk opening inquiry

(line 102) as it straddles both the medical (*you're studying over here medical school*) and

personal (*you're from (FEL's country of origin)*) domains.  The IMG resident's answer *no*

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creates some confusion thus compelling the nurse to inquire again about the IMG resident's native country. In reply he answers with an extended response, agreeing that he is from the country she named and laying out the chronology of his medical education. The nurse gets a little more personal in her next turn in line 139 as she asks what his plans are after completing his rheumatology fellowship. Not yet knowing what he intends to do he replies *that's a good question*. Given his indecision the nurse sees an opening to provide advice and in line 143 urges him to stay in the U.S. citing a shortage of doctors.

As noted previously, the small talk examples shown in Extract 4.36 occur immediately before and after the treatment advice phase. In this way, these small talk episodes serve as transitional talk into and out of the treatment advice phase thus functioning as a relational buffer between the transactional task of discussing treatment. In both examples, in addition to serving a clear interpersonal function, the nurse takes opportunities to provide advice to the IMG resident about what he should do in his future medical career (go into pediatric rheumatology, remain in the U.S. instead of return to his native country). On the part of the nurse, this advice appears to function as face-enhancing moves as she attempts to demonstrate to the IMG resident how his medical expertise could be further utilized. However, depending on the IMG resident's perspective and whether he looks favorably upon this type of advice or not, her advice may be perceived as face-maintaining or face-challenging.

For his part, the IMG resident demonstrated both linguistic and pragmatic adeptness with the transitions between relational and transactional talk. He contributed to the unfolding small talk providing both medical and personal information during his turns. As the small talk topic was limited to the medical domain, of which both interactants are a part, this worked to exclude the patient who does not contribute, except to laugh during humorous sections.

**Express empathy.**

Expressing empathy is a basic relationship management strategy physicians must acquire

as they learn the art of doctoring. According to Coulehan and Block (2006), empathy, along

with respect and genuineness, constitute the three most important therapeutic core qualities

medical practitioners can develop to help foster connections with patients (p. 21). Empathy is a

"type of understanding" (Coulehan & Block, 2006, p. 29) that is expressed through

acknowledging, listening, then responding to the patient (Coulehan & Block, 2006; Frankel,

1995).

Reexamining an interaction previously presented (see "Patient initiated advice" section in

research question one and "Future advice" in research question two), Extract 4.37 occurs with a

female patient during a follow-up Rheumatology visit. The interaction takes place between the

patient and IMG resident during the solo interaction. They had just completed discussing the

possibility of starting a stronger medication in the future. The patient continues to express

concern and seeks a more comprehensive explanation of the progressively worse symptoms she

is experiencing in her hands. Additionally, the patient expresses concern about the genetic link

between her condition and her son's recently diagnosed condition. During this discussion the

patient begins to cry. The extract below demonstrates how the IMG resident handles this

delicate situation requiring intense and immediate empathetic interactional work to acknowledge

and respond to the patient's concerns.

Extract 4.37 RHOI006 Ankylosing Spondylitis
230:     FEL:    it's interesting that you don't have any findings on the x-rays
231:     PAT:    right
232:     FEL:    but your symptoms are so classical
233:     PAT:    uhm uh of the
234:     FEL:    of the
235:     PAT:    [of the AS
236:     FEL:    yeah (1.0) or spondathropala it doesn't have to be AS or this category of

237:          diseases (0.5) uhm especially now that your son has <u>this</u> which these are
238:          two things that they are related actually
239: (18:58)  ((PAT starts to cry))
240: FEL:  **oh I'm sorry (1.0) sorry for that  ((grabs tissues))**
241: (9.0)
242: FEL:  **oh I'm really sorry**
243: PAT:  ((sniffles)) what am I gonna do?
244: FEL:  **no don't worry this we can take care of that kay** an as I said we don't
245:          have to jump into things <u>today</u> uh: but there are medicines that there that
246:          are going to make this easier okay >an they're not so bad< I have people
247:          eighty years old taking these medicines an they're doing pretty well
248:
249: PAT:                                        [okay okay
250: FEL:  I don't imagine <u>you</u> you know get all kinds of infections an everything
251: PAT:  okay
252: FEL:  okay
253: PAT:  yeah it's just scary cuz I've been going through it for so long an then when
254:          he got sick an they told me that it's because (1.0) genetics an I knew it was
255:          from me so now I have to be careful with him
256: FEL:  **it's not your fault okay you didn't do anything <u>wrong</u> okay ah**
257: PAT:  kay well I I know it wasn't my fault it's just that when you know that it's
258:          coming you know he was predisposed an it (1.0) I'm the only one
259: FEL:  **it's not your fault (X) these things happen**
260: PAT:  kay
261: (3.0)
262: FEL:  **you shouldn't feel bad about this it's not <u>you</u> causing him troubles**
263:          people have this disease for centuries now centuries a thousand years
264: PAT:  I understand okay
265: FEL:  okay so let me bring the boss so at least we'll have some fun
266: PAT:  oh yeah ((laugh)) we will here comes Ford gonna come in an ch- cause
               trouble

As the patient starts to cry the IMG resident immediately takes notice of this change in

her disposition and verbalizes in line 240 *oh I'm sorry* (1.0) *sorry for that* while grabbing some

tissues, which he hands to the patient.  After a long pause, in line 242 he repeats his apology,

which is used to express empathy for the patient's concerns.  In her next turn the patient asks

*what am I gonna do?* Phrased in this manner her question seeks advice.  In addition, it is also

possible that the question works to seek additional consolation.  The IMG resident opens up his

next turn with *no don't worry*, offering an additional dose of empathy to reassure her.  To

complete the turn he provides the reasoning behind his "don't worry" remark as he offers her medical counseling.

Beginning in line 253 the patient finally puts words to her emotions as she vocalizes that it is *scary* learning of the genetic connection between her disease and her son's condition. The IMG resident reads into the patient's turn in lines 253-255 self-blame, that is, blaming herself for her son's condition, and with this he adapts his expressions of empathy to accommodate this change in her emotions. In line 256 the IMG resident responds to the patient's self-blame using two declaratives – *it's not your fault* and *you didn't do anything wrong*. Taken together, these declaratives make it clear that the patient is not to blame for her son's condition. He follows each declarative in line 256 with the tag question – *okay* used to seek input from the patient. The patient obliges in line 257 and agrees with the IMG resident's assessment that she is not to blame as she states *I know it wasn't my fault*. Her turn continues in lines 257-258 as she appears to express feelings of helplessness about the situation with her son. Taken together the three phrases – *when you know that's it coming*[31], *you know he was predisposed*, and *I'm the only one* project this feeling of helplessness. The IMG resident does not address these helpless feelings and instead continues to orient to the patient's responsibility as he says *it's not your fault (X) these things happen* in line 259 and *it's not you causing him troubles* in line 262**.** The IMG resident begins to shut down both this sequence and the solo interaction in line 265. To start this turn he says *let me bring the boss* referring to the attending physician and to complete it he says *so at least we'll have some fun*, which juxtaposes the difficult interaction that just occurred with the future conversation with the attending physician that is likely to include "some fun".[32]

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[31] A likely completion to this phrase is *from you* as in *when you know that it's coming from you*.

[32] My observations reveal that the attending physician being referred to in Extract 4.37 had an extremely outgoing and gregarious personality. He used humor on many occasions and throughout numerous interactions that I

Expressions of empathy can occur in countless ways. Extract 4.37 demonstrates one way, exemplifying how a physician uses both verbal and non-verbal (e.g., offers tissue to patient) strategies to attend to the empathetic needs of a distressed patient. As verbal discourse strategies, the IMG resident used expressions of apology and reassurance to acknowledge and respond to the patient's concerns. In response to the patient's concerns, the IMG resident orients to the patient's responsibility in the matter as opposed to her feelings of helplessness and verbalized his reassurance that it was not her fault that her son was genetically predisposed to his condition.

In the interactions I observed there were two examples in which patients cried. In the other example the physician offers "sorry" on two distinct occasions to express empathy to the patient's tearful concern[33]. Consequently, in comparison to this other example then Extract 4.37 serves as an instructive example demonstrating how relational work is used to attend to the face needs of the patient. During this tearful sequence the IMG resident responds with empathetic discourse serving the dual purposes of providing reassurance and attending to and enhancing the face needs of the patient.

**Express concern.**

In addition to expressing empathy, on many occasions physicians are also compelled to express concern about their patients' wellbeing. The following interaction demonstrates such an example in which the IMG resident expresses concern about the patient's thoughts of suicide. This extract occurs during the solo interaction with the patient, patient's mother, and IMG resident in the Rheumatology clinic. We previously saw an interaction with these participants above in the "Sarcasm" section. To review, it is a new patient visit with a patient seeking a

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observed. In addition, the transcript data reveal that several of his patients and the IMG resident comment on, as we see in Extract 4.37, his jovial disposition and its impact on the interactions.

[33] In this example the patient begins to cry when she describes the pain she feels when she "flares up".

second opinion about a recent lupus diagnosis. The interaction in Extract 4.38 occurs only

between the patient and the IMG resident.

Extract 4.38 RHCG004 Undiagnosed
150:    FEL:    have do you recall specific treatment for depression?
151:    PAT:    uhm
152:    1.0
153:    FEL:    Zoloft
154:    PAT:    uhm uh
155:    FEL:    okay are you on anything right now for depression?
156:    PAT:    no
157:    4.0
158:    FEL:    how much of the Alprazolams  are you taking
159:    PAT:    none
160:    FEL:    none?
161:    PAT:    no
162:    3.0
163:    FEL:    what's the Topamax for
164:    PAT:    migraines
165:    8.0; FEL typing
166:    PAT:    the thoughts go through the head (when) I got children I wouldn't do it to
167:            em
168:    FEL:    **yeah but it's still it's still very concerning that you have these thought**
169:            **uhm I mean everyone has difficulties bu:t it's not i i when when you**
170:            **start having these thoughts related ta just stuff that happens ta people**
171:            **on a daily basis it's concerning cuz you need to work that out with**
172:            **someone an an try ta come up with=**
173:    PAT:    =also go to different support groups an stuff so I've got you know I'm
174:            dealing with it but it it's there but wouldn't do it (8.0) I mean coming here
175:            to me is is dealing with it because I've I didn't if I wasn't coming here
176:            (0.5) wouldn't be dealing with it ta me you know what I'm sayin?
177:    3.0
178:    FEL:    have you had any surgeries other than the c section

The extract commences with a line of questioning by the IMG resident to establish the patient's

past and current treatment for depression. After a three second pause she then inquires why the

patient is taking Topamax to which the patient answers *migraines* in line 164. After a long

silence, during which time the IMG resident is typing in the patient's electronic medical record,

the patient acknowledges extremely indirectly that she has thoughts of suicide (lines 166-167).

Using what Levinson (1990) terms "interactive intelligence, the innate human capacity to draw

inferences from ambiguous information", the IMG resident picks up on the patient's suicidal implication and addresses it in the next turn (as cited in Scollon et al., 2012, p. 87). In contrast to the patient's indirect strategy to make this admission, the IMG resident directly and immediately states that she is concerned the patient is having these thoughts. The expression of concern starts the IMG resident's turn in line 168 (*it's still very concerning that you have these thought*)**,** which is followed thereafter with the reasoning for her concern (*when you start having these thoughts related ta just stuff that happens ta people on a daily basis it's concerning*) and advice for trying to cope with the suicidal thoughts (*you need to work that out with someone an an try ta come up with*). The patient interrupts the IMG resident, provides her own method for coping (*also go to different support groups*), and reiterates that she ostensibly has suicidal thoughts that she would not act upon. Following a long period of silence the patient offers another coping strategy (*I mean coming here to me is is dealing with it*) and ends her turn using a tag question (*you know what I'm sayin?*) seeking the IMG resident's input. The IMG resident avoids continual discussion of the topic by not offering additional input and instead, after a three second pause, changes topic to ask the patient about her surgery history.

Clearly, this extract serves as an extreme example of an expression of concern. Two other examples exist in the dataset; both expressions of concern come from the same IMG resident and involve concerns about a patient's failure to communicate her decision not to enroll in a clinical trial and a patient's worsening pulmonary functions. Focusing on the example examined here, it is clear the Rheumatology clinic is not the traditional clinical setting for seeking and giving advice or treatment for depression and suicidal thoughts. However, it would also seem that if a patient verbalizes such potentially life-threatening thoughts during any medical interaction that the modus operandi for any clinician would be to express concern,

discuss contributing factors (i.e., stress, depression) to the suicidal thoughts with the patient, and

seek additional input from a mental health specialist, if necessary.  In this example, the way in

which the IMG resident and patient managed this delicate discussion was professional, non-

judgmental, and non-emotive with both participants attending to the facts.  Moreover, both

participants appeared to favor and focus on transactional as opposed to interpersonal goals

during the exchange.  Though the patient and IMG resident used extended responses, their turns

were logical, efficient but necessary, and attended to the medical task at hand.  In this way and as

regard the relational work on display, this example of expression of concern exemplifies face-

maintaining, politic behavior[34]; neither participant's face was enhanced or challenged during this

delicate sequence.

**Patient Education.**

Displays of relational work not only occur during humorous exchanges or when

empathizing with crying patients but rather can also take place during basic or mundane

participant exchanges.  The basic act of providing information to the patient can also be the site

for relational work.  Along with providing patients information about diagnoses and treatment

options, physicians also take or find opportunities to counsel patients about general health,

medication or other types of information.  Medical information presented in this way is what

Silverman et al. (1992) have termed the "information delivery" format (p. 71).  These data show

that the physicians, both IMG residents and attending physicians, provided patient education in

different areas.  For example, the physicians explained different treatment options within a

medication class, discussed recent research findings about a medication, and described how a

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[34] According to Watts (1989, 2003), politic behavior can be defined as socio-culturally determined behavior directed towards the goal of establishing and/or maintaining in a state of equilibrium the personal relationships between the individual of a social group (p. 135).

medication works in the system.  Moreover, these examples of patient education demonstrate

how physicians attend to both the interpersonal and transactional needs of the interaction.

The data also revealed that how patients responded to these different educational acts

varied.  Though the physicians utilized extended stretches of talk to deliver patient education

(see examples below), the data showed that in most instances patients responded minimally (e.g.,

*uhm uh*, *mkay*), putting them in the role of "passive recipient of generalized information"

(Silverman et al., 1992, p. 73).  Below I show two examples of IMG residents delivering patient

education.

The first example is an extract previously examined in an earlier section (see "Patient

ambivalence toward treatment recommendation" in research question two) to demonstrate how

denial about a diagnosis can lead to equivocation when following the prescribed treatment plan.

The interaction occurs between a female patient and the IMG resident during a follow-up visit in

the Rheumatology clinic.  This extract occurs during the treatment advice phase and, in fact,

serves as the IMG resident's treatment recommendation.

Extract 4.39 RHCG005 Lupus
```
76:     FEL:    …Plaquenil's a pretty safe medication so: I know you you were reluctant
77:             to do the twice daily but I mean really I think eve- every rheumatologist
78:             will tell you they would take it in a minute and they don't have any
79:             problems like if it's their family they wouldn't have any problems
80:             recommending it the only thing that it may cause is that problem with the
81:             eyes but we send you to check and it's very uncommon that it happens so
82:             uhm and it helps a lot of people feel better it also prevents flares uhm
83:             helps prevent flares
84:     (1.0)
85:     PAT:    now the lupus we have stairs at my house
```

The IMG resident's turn, starting on line 76, is a long stretch of talk that serves multiple

purposes.  First, as previously mentioned, this turn functions as an indirect treatment

recommendation.  Secondly, it acknowledges the patient's previously mentioned denial and

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reluctance to take Plaquenil as prescribed (lines 76-77).  With this acknowledgment the IMG

resident displays understanding of the patient's hesitation to follow the treatment advice as

prescribed, thus attending to the interpersonal side of the interaction.  Thirdly, the turn mentions

the medication's relative safety (lines 77-80) as well as risk factors (lines 80-81).  In this turn the

IMG resident constructs a persuasive argument, emphasizing consensus of the medical

community (i.e., every rheumatologist) while minimizing the risks as minimal and exceptional.

Clearly, these are important educational points that serve a transactional function but the manner

in which the IMG resident formulates these points by mentioning how doctors themselves would

take the medication and prescribe it to their family members adds affect to the formulation.  The

final purpose of the IMG resident's turn mentions Plaquenil's beneficial health outcomes (lines

82-83).  Serving a transactional function, these general health benefits are likely familiar to the

patient.  However, the IMG resident's use of the noun *people* may serve to affiliate or distance

the patient from this generic group depending on her own self-perceived benefits of the

medication.

In sum, this stretch of discourse serves the dual role of patient education and an indirect

treatment recommendation.  Moreover this extract nicely demonstrates a blending of the

interpersonal and transactional functions of relational work.  On the interpersonal side there is an

acknowledgement of patient's concern and expression of reassurance.  On the transactional side,

the IMG resident's work serves as patient education.  These relational functions work together as

a way to either demonstrate the beneficial effects of the medication or, at a minimum, as a way to

persuade the patient to take the medication as prescribed.

As discussed in the previous section, the patient does little with the information just

received.  In fact, she fails or chooses not acknowledge any of what the IMG resident has said

with the change of topic in line 85.   Consequently, it is unclear the effect this educational

discourse had on her attitude about her condition and willingness to take the medication as

prescribed in the future.

The second example of patient education occurs with the same IMG resident as the

previous example.  This interaction takes place with a new patient.  During this medical

encounter the attending physician recommends weaning off two medications – Hydralazine and

CellCept – and a test for her thyroid.  Extract 4.40 below occurs between the patient and IMG

resident in the closing phase of the interaction after the supervising attending physician has left

the examination room.

Extract 4.40 RHCG004 No diagnosis
```
552:    FEL:    you have uncontrolled blood pressure despite being on three anti-
553:            hypertensives an you have low potassium sometimes not always
554:            sometimes that can be related to an abnormal hormone in your blood so
555:            you can uhm have em check fer that u:hm the other thing is steroids
556:            doesn't help the fact that you had doesn't help your blood pressure it
557:            actually increases it so that can also be in part why you're having
558:            difficulty controlling your blood pressure
559:    PAT:    okay
560:    FEL:    uhm as he mentioned let's stop the Hydralazine uhm but don't do it on
561:            your own
562:    PAT:    no
```
(Continues discussion about stopping Hydralazine under the patient's primary care physician
supervision)
```
578:    FEL:    we'll send him a copy of what our assessment is our findings are planned
579:            uhm I do suggest tapering the steroids i- in the future if we don't find cuz
580:            we'll repeat all the labs in the future but if there's no evidence of
581:            inflammation I don't see why we should keep you on a medication that
582:            causes increased blood sugars diabetes an high blood pressure an
583:            osteoporosis too in the long term so uhm: hopefully we can wean you
584:            down in the future from that medication an then uhm try ta find
585:            medications that work for your diffuse pain cuz I suspect you either have
586:            something with your thyroid or you may have fibromyalgia or depression
587:            so these are things that don't aren't treated with steroids treated with other
588:            treatment an we have ta getchyou on the right thing so you can get better
589:            okay?
590:    PAT:    uhm uh
591:    FEL:    be patient cuz a lot of these things take a lot of time ta figure out what they
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592:         are okay? uhm an that's all I can say right now we'll see you back in four
593:         weeks
594:    PAT:   okay
595:    FEL:   sounds good?
596:    PAT:   peachy

It is clear that the IMG resident's first two long stretches of discourse (lines 552-558 and lines 578-588) work on a transactional level to summarize the physicians' findings of the patient's presenting symptoms and condition. In turn, these long summarizations serve as a source of education for the patient. Through these turns the patient learns, if she is not aware already, that her blood pressure is not under control and some of the potential contributing sources (abnormal hormone, steroid use). Moreover, she learns of the additional effects of steroid use on the body (*increased blood sugars diabetes an high blood pressure an osteoporosis too in the long term*). Thereafter, and based on the evidence collected thus far, the IMG resident offers her initial assessment of the patient's condition in lines 585-586 (*I suspect you either have something with your thyroid or you may have fibromyalgia or depression*). These turns serve to transact the medical business at hand by providing the patient (and patient's mother) with information about her condition, medication effects, and potential diagnosis.

Starting on line 588 the IMG resident's discourse begins to change as the function it performs shifts from transactional to interpersonal. The first instance of this shift occurs as she terminates her second long turn with *we have ta getchyou on the right thing so you can get better okay?* This closing phrase works as an affiliative move, demonstrating concern for the patient's health and wellbeing and also showing the patient that decisions are being made in her best interest. In addition, she seeks further affiliation with the patient through the use of the rising-intoned tag question *okay*, signaling patient input. The patient consents but responds minimally with *uhm uh* in line 590. This minimal response provides an opening for the IMG resident to

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retake the floor; she tells the patient to *be patient* because it may take some time to reach a diagnosis. This move provides an honest assessment of the medical diagnostic process, especially given the patient's complex history and case and it also serves as a relational move as the IMG resident both asks for and demands patience. That is to say, it appears she is asking the patient to be patient with her and the attending physician as they work through her complex case to come to a diagnostic decision and determine the best course of treatment for her. Moreover, through the use of the imperative she directs the patient to be patient again with the process and herself. As a team, both physicians and patient will work collaboratively and patiently through the process to reach a favorable health outcome. The IMG resident makes one more affiliative move with *sounds good?* in line 595. Phrased in a positive way, a correspondingly positive response is anticipated from the patient; she obliges with the exceedingly upbeat response *peachy* to close out this sequence.

These two extracts demonstrate how the IMG resident's delivery of patient education attended to both the transactional and interpersonal aspects of the relationship. My analysis demonstrated how the IMG resident delivered patient education and how she utilized different delivery methods in each example to do so. In Extract 4.39 she blended the transactional and interpersonal functions into her long stretch of discourse, acknowledging the patient's resistance while simultaneously addressing the medication's relative safety and health benefits. In comparison, in Extract 4.40 the IMG resident handles the transactional and interpersonal functions of the discourse in a sequential manner; first she managed the transactional business of the interaction by summarizing the patient's present condition then she shifted focus to the interpersonal side of the interaction through a series of affiliative moves.

Based on these two examples and the others in the dataset, it would appear that the act of providing patient education works to maintain face for both physician and patient. These examples of patient education demonstrate politic behavior as the interactants work to maintain their interpersonal relations. A key factor in establishing patient education as politic behavior seems to be topic. That is, the verbalization of basic information from physician to patient is a neutral topic. In other words, the information being provided is not specific to the patient but is rather general information and applies to a broad population.

**Confrontations.**

In the section that follows I provide examples of three different types of confrontational interactions between IMG residents and their patients. The three types of confrontations are complaints, conflict, and resistance. I group these examples together because the ways in which the confrontational discourse is initiated and managed share similar characteristics. In the examples presented below, the patients initiate the confrontation and it is up to the IMG residents to determine how to handle and respond to them. In other words, in their responses do the IMG residents utilize discourse strategies to escalate or diffuse the patients' confrontation? The data reveal that the IMG residents handle these confrontational interactions using similar discourse strategies. The important contextual factors that may contribute to these similar responses are explored as well as the influence these strategies have on the relational side of the interaction.

*Manage conflict.*

There are times in medical encounter interactions that less than harmonious situations occur, which result in face management skills to be called upon. In these data there is only one example, which I characterize as conflictual. Moreover, as will be demonstrated below, the conflict is one-sided; in other words, the conflict arises from the talk of only one of the

participants and it does not escalate once the second participant is engaged. Thus, from a relational work perspective this example demonstrates the discourse strategies used to both initiate and manage the conflict so that both the interpersonal and transactional goals of the medical encounter are attended to.

The extract comes from an interaction between a patient and the IMG resident in the Neurology clinic. The visit is with a new patient who presents with a headache. A longer version of this interaction was previously presented (see "Patients' utilization of questions" section in research question three) to examine the patient's use of questions while treatment advice was being given. The IMG resident opens up the sequence in line 62 below:

Extract 4.41 NESG004 Headache No diagnosis
```
62:    RES:   alright hang in here I'm gonna go talk to my attending and come back now
63:           ho- now (0.5) what do you want us to do with your headache do you want
64:           to get to start a new medication or are you happy with how your headache
65:           is er what do you want to do?
66:    PAT:   I don't know you're all the doctor ya'll got to tell me I have no I have no
67:           earthly idea what is going on
68:    RES:                                                        [how (X)
69:    RES:   okay
70:    PAT:   ya'll are the specialists so that's why I'm here
71:    RES:   [how                        [how how bad is your headache how much is it
72:           bothering you
```

In line 62 the IMG resident states that he is going to go talk to his attending physician about her condition. Instead he pauses and initiates a discussion of future treatment. In a rather long turn, which poses four different questions to the patient, he attempts to seek her input on treatment. His solicitation is met with resistance as the patient chooses not to provide input about what to do with her headache. In addition, this could be viewed as a combative response by the patient as she unloads on him – *I don't know you're all the doctor ya'll got to tell me I*

*have <u>no</u> I have no earthly idea what is going on.*[35]  Her turn is clearly a face-challenging response.  In response to this challenge all the IMG resident is able to muster is *okay*.  This response appears to be treated as a continuer by the patient because in her next turn she continues with another face-challenging response – *ya'll are the specialists so that's why I'm here*.  The IMG resident attempts to overlap with a question (*how*) but he is either cut off or stops talking.  He finally gets his question out when he asks *how how bad is your headache how much is it bothering you* in lines 71-72.  Hereafter, the tone of the interaction moderates as the IMG resident and patient move into a question-answer sequence and a discussion of a treatment option.

It seems reasonable to characterize the patient's two consecutive responses in lines 66-67 and 70 as conflictual.  The question is:  what may have contributed to this conflict and how was it managed?  In terms of the IMG resident's contribution, it is conceivable that the quality and quantity of questions in lines 62-65 may have initiated the verbal backlash.  The IMG resident strings together four different interrogatives, one of which is phrased in a rather unusual manner (*are you happy with how your headache is*).  This series of questions may have come as a surprise to the patient or may have even confused her, thus provoking the strong, face-challenging statements.  The IMG resident maintains his professionalism and does not, to his credit, escalate the conflict.  Neither does he, however, reassure the patient that he will do something medically for her headache.  In lieu of this approach, he utilizes a series of additional questions (not shown here) to maintain a civil and transaction-oriented interaction and to keep the conversation moving toward a treatment plan.  This thus becomes his conflict management technique to get out of a "sticky" interactional situation.

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[35] Reviewing the patient survey data related to this interaction it is interesting to note that in response to question ten on the survey (see Appendix C), the patient selected *combative* to describe the relations with the physicians.

As regard the patient's contribution to this conflict, there are several factors worth noting that may help to explain her confrontational response. It is possible she did not want to provide input or be consulted about treatment for her headache. Furthermore, in past medical encounters she may never have been consulted or brought into the decision-making process. Consequently, the IMG resident's solicitation may have been unfamiliar and unexpected, thus provoking a negative reaction. Additionally, she may have different expectations about how medical encounters are conducted and the roles physicians and patients are expected to play. As a result these expectations and prior experiences may have influenced the development of the interaction. As a final consideration and as Heritage and Robinson (2006) demonstrate some patients require validation that their symptoms and medical visit were deemed "doctorable" and indeed in need of treatment. Therefore, the patient may have perceived the IMG resident's solicitation as a question about the seriousness of her symptoms that brought her to the clinic in the first place.

### *Manage complaints.*

Previous research has shown that complaints are a delicate and complex social phenomenon that, interactionally speaking, are typically embedded in ongoing talk, delivered indirectly, and are on the surface considered somewhat risky or face-challenging (Heinemann & Traverso, 2009; Ruusuvuori & Lindsfors, 2009; Vásquez, 2009). Heinemann and Traverso (2009) tell us that "to complain means to express feelings of discontent about some state of affairs, for which responsibility can be attributed to 'someone' (to some person, organization or the like)" (p. 2381). A complaint can serve as an affiliative or dissaffiliative move, hence the riskiness of the act. The affiliative/dissaffiliative outcome depends on a couple of factors: 1) whether the recipient of the complaint elects to respond to or engage in the complaint activity

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once a complaint is delivered or; 2) if the complaint is delivered whether the recipient of the complaint aligns with the complainant's viewpoint or not (Heinemann & Traverso, 2009).

Another key feature made salient by previous research is the notion of direct and indirect complaints.  Complaints are categorized as direct when the recipient of the complaint and doer of the complainable action are the same individual.  Indirect complaints, sometimes labeled third-party, are complaints about someone or something other than the recipient of the complaint (Heinemann & Traverso, 2009; Ruusuvuori & Lindsfors, 2009; Vásquez, 2009).  In these data there are two examples of patient complaints.  In both examples the patients lodge complaints about medications that have been previously or currently administered.  Thus, these complaints may be categorized as indirect complaints.

Turning to the data, the first example comes from an interaction between the IMG resident, patient, and patient's husband during a follow-up visit at the Rheumatology clinic.  We have seen these interactants in previous sections jointly constructing the treatment advice phase.  This sequence occurs immediately following treatment advice discussion as the IMG resident asks the patient about her symptoms after stopping a medication (Plaquenil).

Extract 4.42 RHOI008 Lupus

| 184: | FEL: | right an did you feel that became worse after you stopped the |
|---|---|---|
| 185: | | Plaquenil |
| 186: | PAT: | ew the Plaq- |
| 187: | PAT HUS: | you know the Plaquenil the first medication you were taking |
| 188: | PAT: | [yeah |
| 189: | PAT HUS: | when Dr. Ford took you off an put you on Dapson |
| 190: | PAT: | yeah I I don't like the Plaquenil |
| 191: | FEL: | **no no no my question is did the skin became worse when we** |
| 192: | | **stopped the Plaquenil or you stopped the Plaquenil** |
| 193: | PAT: | no I don't think so |
| 194: | FEL: | no became better |
| 195: | PAT: | kinda stayed |
| 196: | FEL: | kinda stayed |

After asking the patient to describe her skin condition after stopping the Plaquenil, the patient provides a short but negative response in line 186. This response, coupled with her more directly formulated evaluation about the medication in line 190 – *yeah I I don't like the Plaquenil* – form the basis of her complaint. It is possible the patient makes use of repetition here to make her complaints known because she is concerned the IMG resident raised the topic of Plaquenil to put her back on it. Consequently, these complaints are used to index her negative feelings about the medication.

The IMG resident starts his response to this series of complaints in line 191 with the repetitive use of the lexical item *no* signaling, at least from his perspective, that there is a misunderstanding. The IMG resident's successive use of *no*s aligns with Stivers (2004), which showed that multiple sayings such as this serve as a resource for interlocutors to display that they are dealing with "an entire course of action and not only the just prior unit of talk" (p. 269). Immediately following the *no*s, he restates his original question (lines 184-185) asking her to describe the effect stopping Plaquenil had on her skin condition. Over the next several turns the patient and IMG resident jointly establish that her skin *kinda stayed* the same.

As we saw above, the patient uses the IMG resident's opening question about Plaquenil as an opportunity to provide her negative evaluation of the medication. We see, however, that the IMG resident, maintaining a professional role, does not directly take up the patient's complaints. In fact, it appears he perceives it as unnecessary due to the patient's misunderstanding about the content and meaning of his question. Instead, the IMG resident sticks to the medical task at hand. He redirects the patient's focus back on symptoms as he inquires whether *the skin became worse* after the medication was stopped.

The second extract demonstrating how the IMG resident manages her patient's complaint also comes from a Rheumatology follow-up visit. This medical encounter occurs with a female patient with rheumatoid arthritis. The extract shown below occurs at the beginning of the interaction as the IMG resident is establishing how the patient is doing on her current medications. At the time of the interaction the patient was tapering off of steroids. Upon raising this topic, the patient uses complaints to discuss the effects of steroid use on her body.

Extract 4.43 RHCG008 Rheumatoid arthritis
43:    FEL:   cuz we were still coming down off the steroids at that point right?
44:    PAT:   right right and now I'm down to the ten milligrams a day but look at the
45:              size of me
46:    FEL:         [uhm uh
47:    PAT:   you know I I I just I can't take steroids this is
48:    FEL:   yeah no an an this
49:    PAT:   who I am now an an I hate that I've always complained about that from
50:              day one
51:    FEL:   [no we're
52:    FEL:   **the plan is to eventually bring you off of the steroids**
53:    PAT:   right
54:    FEL:   **uhm an that's why we're trying to get everything set up so that we can**
55:              **give you the medications you need for your rheumatoid**
56:    PAT:   right

The patient's first complaint appears in lines 44-45 – *but look at the size of me* – referring to the weight she has gained, in part, due to steroid use.[36] After stating her preference to stop taking steroids (line 47) the patient adds two more complaints:  1) *this is who I am now*; and 2) *I hate that I've always complained about that from day one*.  In sum, these three complaints paint a picture of a patient who is dissatisfied with the medication's side effects on her body.

During this sequence, which features overlapping turns and interrupted sentences, the IMG resident attempts to interject (in lines 48 and 51).  She is finally able to secure the floor to address the patient's concerns in line 52 as she lays out the future treatment plan – *the plan is to*

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[36] Later in the solo interaction and on two separate occasions, the patient refers to her body as "big as a house".  This self-evaluation is made as the discussion continued about the patient's history of steroid use.

*eventually bring you off of the steroids.*  The patient concurs in line 53 with *right* and in the following turn the IMG resident provides additional details about the future treatment plan.

Similar to Extract 4.42 above, this example demonstrates how the IMG resident remains focused on the medical task in the face of the patient's complaints.  That is to say, she does not directly address the patient's dissatisfaction and side effects pertaining to steroid usage.  In remaining focused on the future treatment plan, the IMG resident addresses the patient's complaints indirectly.  In other words, if she goes completely off steroids or tapered to a lower level her complaints about weight gain will eventually be addressed.

As Heinemann and Traverso (2009) point out "who complains, about whom/what to whom" (p. 2382) are salient features to consider when analyzing how a complaint affects an interaction and relationship of the interactants.  In both examples the patients lodge complaints about medications and their side effects to the IMG residents.  The upshot of the complaints is that the IMG residents elect not to take an affiliative stance with the patients and their complaints but rather choose to remain focused on the institutional task of devising a treatment plan. The IMG residents' management of the complaints is consistent with Ruusuvuori and Lindfors' (2009) study, which found that medical professionals "ignored the complaining aspect of the turn of talk and continued the conversation toward the management of the ongoing business" (p. 2416).

Thus, these data illustrate how the locally-situated context affected the unfolding of complaints.  As other studies examining complaints in an institutional setting (e.g., Orthaber & Márquez-Reiter, 2011; Ruusuvuori & Lindsfor, 2009; Vásquez, 2009) have demonstrated, these patient complaints were constrained by a variety of institutional factors.  The factors that influenced these complaints are:  1) the medical institutional setting, 2) the professional role

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assumed by the recipient of the complaint, the IMG resident and; 3) the asymmetrical

relationship between physician and patient (see section below for a further discussion). These

examples demonstrate that it is likely that physicians hear a myriad of complaints from their

patients about their medications and side effects they experience on a daily basis. Given this,

IMG residents need to be mindful about which complaints they attend to for several reasons: 1)

will hearing the complaint in full take the conversation off topic and extend the interaction

unnecessarily? 2) will the nature of the complaint require the need for extra face work? 3) will

affiliating or disaffiliating with the patient's complaint undermine the IMG resident's

professional role? Thus, as professional representatives of the medical institution, to engage in

the relational work necessary to attend to all such types of complaints may prove to be an

overwhelming proposition requiring an adept and agile assessment of the unfolding situation.

### *Express resistance.*

Previous research has shown that patients on occasion display resistance to physicians'

treatment decisions (Koenig, 2008; Stivers, 2005b, 2006). According to Stivers (2006),

"resistance can be understood as a communication practice through which patients can,

intentionally or unintentionally, place pressure on physicians that alter their treatment

recommendation" (p. 299). Additionally, Koenig (2008) demonstrates that some patients resist

in order to solicit additional information or to reveal specific treatment preferences. Patient

resistance can take either passive or active forms and may initiate negotiation about treatment.

In these data there are six (21%) interactions in which patients display resistance during

the medical encounter. In these interactions the patients display both active and passive forms of

resistance and the resistance sequences occur during various phases (e.g., opening, treatment

advice) of the medical encounter. I share two examples, one example occurred during the

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opening phase and the second example occurred during the treatment advice phase with the IMG resident, to illustrate how the patients use different discourse strategies to express resistance and, in turn, the discourse strategies IMG residents use to manage the resistance. In the first example the patient expresses resistance explicitly and in the second example the patient employs a passive resistance strategy during discussion of future treatment. In both cases the patients have been diagnosed with psoriatic arthritis.

The first extract comes from a follow-up visit with a patient at the Rheumatology clinic. We have previously seen other extracts from this medical encounter (see "IMG resident initiated advice" section in research question one and "Spontaneous treatment advice" in research question two). The female patient is diagnosed with psoriatic arthritis and has experienced increased arthritic symptoms since her last visit. The medication Arava was stopped recently because of concerns about high blood pressure. This extract occurs during the opening phase of the solo interaction with the IMG resident. The patient has just completed giving a detailed description of her new symptoms (e.g., increased swelling, soreness, tenderness, and grip loss) as the IMG resident shifts the conversation to previous treatments the patient has tried:

Extract 4.44 RHCG006 Psoriatic arthritis
```
65:     FEL:   remind me u:hm: other than the: uhm Arava what have we tried?
66:     PAT:   uhm we've tried uhm ᴼoh godᴼ
67:     FEL:   Methotrexate?
68:     PAT:   no we haven't
69:     FEL:   okay
70:     PAT:   uhm
71:     FEL:   uh Enbrel?
72:     PAT:   no
73:     FEL:   [Humira?
74:     PAT:   I haven't tried any of those that was our next I I was (1.0) resistant to
75:            doing anything like until I absolutely had to
76:     FEL:                              [uhm uh
77:     FEL:   mkay an then the Arava you actually tolerated it well how bout the
78:            response:?
79:     PAT:   uhm I felt it was okay
```

Lines 65-66 show that both IMG resident and patient are struggling to remember the previous medications the patient has tried prior to Arava. Given their collective lack of recollection, the IMG resident begins listing some possibilities – *Methotrexate?* (line 67), *uh Enbrel?* (line 71), and *Humira* (line 73). To Methotrexate and Enbrel the patient answers *no* (lines 68 and 72), she has not tried those medications. In line 74, after the IMG resident asks about Humira, the patient responds *I haven't tried any of those* but appears to recollect that Humira was the next medication they were going to start (*that was our next*). Immediately after and in the same turn, she starts in *I I was* and after a one second pause states that she was *resistant to doing anything*. With this statement the patient explicitly verbalizes her resistance to trying any medications. She intensifies her resistant stance, using an extreme case formulation (Pomerantz, 1986) as she continues *until I absolutely had to*, which complete her turn. In response to the patient's expression of resistance, the IMG resident provides an overlapping *uhm uh* and immediately returns to the topic of Arava to ask how she tolerated it in lines 77-78.

This extract demonstrates how a patient and IMG resident manage resistance to future treatment options. In this example the patient utilizes a direct statement to express her resistance indexing her agency to participate in and make treatment decisions that are right for her. It is unclear, however, to which type(s) of treatment the patient is resistant as she leaves this important piece of information unsaid during her statement (*doing anything like* in line 75). However, it seems clear that the patient chooses to rely on an evaluation of her symptoms and day-to-day condition as barometers for making treatment-related decisions. In response to this expression of resistance, the IMG resident chooses not to further explore the topic with the patient. This is demonstrated by the IMG resident's minimal response (*uhm uh*), topic shift in lines 77-78 and the fact the topic does not resurface in the remaining phases of the solo

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interaction. This resistance statement during the solo interaction was not an anomaly as the

patient restates her resistance using nearly the same formulation (*I'm resistant I want ta wait till I*

*absolutely had to*) during the joint interaction. In the end, during this visit the patient relents,

recognizing the fact that her physical symptoms are getting worse and agrees to take the

medication Enbrel.

In contrast to the active, explicit display of resistance in Extract 4.44 above, the second

example illustrates a patient's use of passive resistance. The interaction occurs between a patient

and the same IMG resident in the Rheumatology clinic. It occurs while the IMG resident is

offering treatment advice to the patient. The IMG resident makes two different solicitations

seeking the patient's input on treatment. The first option asks the patient to consider staying the

course with the current treatment (Methotrexate). The second solicitation, displayed below,

proposes an alternative treatment option.

Extract 4.45 RHCG007 Psoriatic arthritis
| | | |
|---|---|---|
| 186: | FEL: | how about uhm (1.0) so I I don't know if this is what he's gonna |
| 187: | | recommend but if he <u>does</u> recommend escalating treatment ta like an IV |
| 188: | | infusion |
| 189: | PAT: | uhm uh |
| 190: | FEL: | would you be able ta come in? ta do that? |
| 191: | PAT: | **I have ta come to (city name) every month?** |
| 192: | FEL: | uhm (1.5) where do you live |
| 193: | PAT: | in (county name) county (city name) **I mean I can do it I (X) I need it to** |
| 194: | | **be late I can't leave work eve(h)ry mo(h)nth** |
| 195: | FEL: | yeah (1.0) well I mean the the initiating the treatment is usually what's |
| 196: | | more tedious because it's like zero two on whatever weeks an but then |
| 197: | PAT: | [mhm mm |
| 198: | FEL: | actually wh- wh one of the infusions uhm I think can be spread out even |
| 199: | | like every eight weeks |
| 200: | PAT: | mhm mm that would (X) |
| 201: | FEL: | but it's even every two months it's although you at first the first month |
| 202: | PAT: | [yeah |
| 203: | FEL: | you're gonna have ta do it a few times |
| 204: | PAT: | uhm uh |
| 205: | FEL: | uhm later on it will be more spread out and that one can be adjusted fer |
| 206: | | your weight |

```
207:    PAT:    uhm uh
208:    FEL:    uhm we can actually push it a little bit closer as well if you're not
209:            responding
210:    PAT:                                                      [mhm mm
```

In the IMG resident's opening turn she solicits the patient's input into whether she would
be willing to come to the clinic to receive IV infusions (lines 186-188 and 190). The patient's
first indication of passive resistance occurs in line 191 as she responds with a question of her
own – *I have ta come to (city name) every month?* The IMG resident asks the patient where she
lives and in line 193 the patient states the county and city. The distance between the city where
the patient lives and the clinic is approximately 30 miles. Given this rather lengthy distance, it is
possible that her question – *I have ta come to (city name) every month?* – indicates some
unwillingness to travel frequently to receive treatment. She continues her turn and takes another
resistant position when she finally answers that she can come in to receive treatment but only late
in the day because she cannot leave work every month. In this turn, the prosody of the patient's
statement *I can do it* suggests hesitation and, as indicated by the transcription, the patient uses
breathy laughter in her utterance *eve(h)ry mo(h)nth*. Taken together, these prosodic patterns
exhibit a less than firm commitment to starting this type of treatment. Thus, while the patient
softens her position about her willingness to receive this treatment in lines 193-194, she places
some conditions on it (*I need it to be late*) and, as noted, the intonation she uses in some parts of
this turn indicate some resistance to this treatment possibility.

Over the next several turns the IMG resident explains to the patient how the treatment is
administered. Throughout the IMG resident's explanation, the patient responds minimally: *mhm
mm* in line 197, *yeah* in line 202, *uhm uh* in lines 204 and 207, and *mhm mm* in line 210.
Consequently, over this stretch of talk, as the patient continues to respond minimally, the IMG
resident simultaneously pursues her acceptance of the treatment option, as evidenced by her

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lengthy explanation. Hearing no overt acceptance of this treatment proposal, the IMG resident regards her minimal responses as passive resistance (Heritage & Sefi, 1992; Stivers, 2005b, 2006). In this way, the IMG resident's and patient's turns serve as a counterbalance with passive resistance and active pursuit of acceptance working in opposition, resulting in this protracted negotiation.

Additional evidence is found in other sections of the interaction suggesting that the patient is perhaps more content taking another form of medication and she may require additional convincing to start this alternative form of treatment. On two occasions the patient gives an indication that she prefers to take Prednisone as a part of her treatment plan. When the IMG resident asks the patient which treatment gives her the most results the patient responds: *steroids always work*. Furthermore, when the attending physician asks her if she thinks Methotrexate is helping she states: *not that I can tell I mean every time I get off my Prednisone I'm back ta where I can't do anything*. Thus, with these firm responses the patient is choosing to demonstrate to her physicians that her physical symptoms respond well to Prednisone. Additionally, the responses may function as implicit suggestions, hinting that she prefers to continue with this medication.

In addition, during the joint interaction, and on two separate occasions, the attending physician suggests that the patient give consideration to the IV infusion/biologic treatment. In the first instance he states that if the Arava does not work (the medication prescribed to the patient during this medical encounter) *then we might have to revisit the possibility of the TNA the biologic the Enbrel* and again toward the end of the interaction he states *if it doesn't help (1.0) think about it okay we might have to go a biologic*. To each of these suggestions to "think about it" the patient does not respond. Thus, the patient's continued lack of response, in conjunction

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with her minimal responses exhibited in Extract 4.45, further illustrates some resistance on her part to consider this new treatment.

This extract, along with the supporting evidence, demonstrates how a patient uses an alternative form of resistance, passive resistance, to a treatment recommendation and the way in which the IMG resident manages the interaction. The patient utilizes different verbal strategies – a question, an account, and minimal responses – and non-verbal strategies – hesitation and breathy laughter – to passively resist the recommendation. To manage this passive resistance, Extract 4.45 demonstrates how the IMG resident uses multiple turns to account for the treatment administration process and to actively pursue the patient's acceptance. In the end, this treatment negotiation does not result in the patient agreeing to the recommendation. Instead, the IMG resident changes topic to the patient's immunization record (data not shown here). It is possible the IMG resident did not continue to pursue the patient's acceptance due to the fact the topic of future treatment would be taken up again during the joint interaction with the attending physician. Moreover, the recommendation to start IV infusions was merely a possible future course of action; therefore, an active pursuit of acceptance may not be applicable in this case given the incertitude.

In this section I chose two different examples to illustrate patient's resistance to treatment. Following previous research, these examples demonstrated that patients use both active and passive forms of resistance during the medical encounter. Previous research has focused on patient resistance during the treatment advice phase (Koenig, 2008; Stivers, 2005b, 2006). These data show that displays of resistance can also occur during the opening phase. In this instance, the patient utilized an explicit statement to make known her desire to avoid treatment until

absolutely necessary.  With this statement the patient not only sets the tone of the ensuing interaction but also makes known upfront that a negotiation about treatment should be expected.

In both examples the IMG resident managed the patients' resistance by changing topic immediately after the episodes of resistance was completed.  The literature demonstrates that when patients resist treatment physicians use different discourse strategies (e.g., offering additional recommendations, referencing diagnostic findings, initiating new sequences) to convince or pursue patient's acceptance of the treatment recommendation (Stivers, 2006).  These examples add to this extant body of literature and provide additional evidence to suggest that physicians manage and respond to resistance in different ways.  These data suggest that the pursuit of patient's acceptance is not always the strategy physicians turn to in the face of resistance.  These data demonstrate that physicians change topic as a way of managing (or not) patient's resistance.  An explanation for this difference in physician response may be the placement of the resistance sequence in the medical encounter.  In both examples opportunities remained in the joint interaction with the IMG resident and attending physician to explore further the patient's perspective and attitude vis à vis treatment options.  In addition to placement, another aspect to consider is who is receiving the resistance.  In other words, it is not the attending physician but rather the IMG resident, the minor authority figure in these cases, who is obliged to manage the resistance.  The IMG resident's experience level and past opportunities to participate in this more challenging type of discourse may be factors to consider in how it is managed in the end.

In summary, in this section I analyzed five different examples of interactions between patients and IMG residents, which, on the surface, could be characterized as confrontational. Patients used conflict, complaints, and resistance as a way to avoid a treatment advice

solicitation and to express attitudes about different medications. From a relational perspective,

these confrontational acts may cause a strain on the interpersonal relations with the IMG

residents, potentially leading to an escalated or heated conversation. Importantly, how the IMG

residents handled and responded to the patients' confrontational turns affected the ways in which

the interactions move forward. Of the three confrontational acts, the conflictual discourse in

Extract 4.41 was the only example that could be labeled face-challenging as the patient

challenged the IMG resident's solicitation for her input to open up the treatment advice phase.

The relational practices in the other two confrontational acts – complaints and resistance –

resulted in the maintenance of face as the IMG residents used varied discourse strategies to

effectively manage the confrontational sequences.

As discussed briefly above in the section on complaints, several contributing factors help

to explain why none of these confrontational interactions resulted in an escalated or heated

conversation. First, for each type of confrontation the IMG residents utilized different discourse

strategies to manage, as oppose to escalate, the confrontation. To manage conflict in Extract

4.41 the IMG resident falls back on the standard question-answer sequence, a basic medical

communicative practice, to mitigate the patient's escalated turn. With this retreat to an arguably

more comfortable interaction strategy, especially for an IMG resident, his additional questions

deflect the conflict and return focus to the medical domain, specifically determining a future

treatment plan for the patient. In Extracts 4.42 and 4.43 the IMG residents also took a

transactional orientation in the face of patient's complaints. In these examples the IMG residents

choose not to take up or respond to the patients' complaints thus making no affiliative move to

orient to or align with the patients' complaints. Additionally, due to the fact the object of the

patients' complaints – their medication and side effects – fell within the medical domain, and

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were not directed at an individual, made it interactionally less burdensome for the IMG residents

to maintain a transactional orientation.  In the third example of confrontational acts in which

patients expressed resistance, Extracts 4.44 and 4.45 illustrated that IMG residents took a

different approach to manage the resistance.  The examples showed that the IMG resident elected

to change topic as a way to responsively handle patients' active and passive expressions of

resistance to treatment options.

Coupled with these different discourse strategies (i.e., question-answer sequence,

disaffiliative stance, topic change) utilized to manage confrontations and sustain a

transactionally-oriented interaction, social setting and roles also influenced the ways in which

these confrontations were managed. The professional medical setting, participant roles, and

asymmetrical relationships between physician and patient constrained the relational practices and

contributed to the largely face-maintaining, politic behavior evinced in these examples.

Consequently, these examples serve as exemplars of how physicians employ various relational

and discourse strategies to maintain a transactional orientation and manage confrontations during

the medical encounter.

**Conclusion.**

In this section I explored the multiple discourse strategies physicians and patients use to

co-construct, maintain, and manage relations during medical encounter interactions.  Specifically,

I analyzed 13 different examples exploring nine different relational functions.  Table 8 below is

used to summarize the nine different functions explored in this section.  Table 8 is similar to

Table 7 displayed earlier in this section, however I added two columns (participant(s) who

receives function and facework) to Table 8 for clarification and informational purposes. The

table displays the relational work function, which participant initiated the function, which

participant received the function, and in which phase of the medical encounter the function was

used.

Table 8

*Examples examined of Relational Work by Function*

| Function | Participant who initiates function | Participant(s) who receives functions | Phase in which function is used | Facework | Goal |
|---|---|---|---|---|---|
| Humor | IMG resident Patient | Multiple | Treatment advice phase | Enhancing Challenging | Interpersonal and Transactional |
| Sarcasm | Patient | Multiple | History taking phase | Challenging Preserving | Interpersonal |
| Small talk | Nurse | IMG resident | Treatment advice phase | Enhancing Maintaining Challenging | Interpersonal |
| Express empathy | IMG resident | Patient | History taking phase | Enhancing | Interpersonal |
| Express concern | IMG resident | Patient | History taking phase | Maintaining | Interpersonal and Transactional |
| Deliver patient education | IMG resident | Patient | Treatment advice phase Closing phase | Maintaining | Interpersonal and Transactional |
| Manage conflict | Patient | IMG resident | Treatment advice phase | Challenging | Transactional |
| Manage complaints | Patient | IMG resident | History taking phase Treatment advice phase | Maintaining | Transactional |
| Express resistance | Patient | IMG resident | Opening phase Treatment advice phase | Maintaining | Transactional |

Additionally, the facework (face enhancing, face maintaining, face challenging) that emerges as a result of the interaction and the goal (interpersonal, transactional, or both) achieved through the function are also displayed. These data demonstrated that instances of relational work occur across all phases of the medical encounter and all participants engage in it to simultaneously achieve medical goals and maintain good interpersonal relations.

Turning attention to the main participants of the study, the IMG residents, this section demonstrated what IMG residents can do relationally with their patients. The significance of this section was to demonstrate, as physicians-in-training and more importantly as physicians-in-training using an L2, their sociopragmatic abilities while interacting with their patients in the medical encounter. Thus, using relational work and taking a discursive approach provided a useful lens through which to examine their sociopragmatic abilities and pragmatic competence. The interactional data in this section showed that the IMG residents performed across a range of relational functions and used a variety of discourse strategies during interactions with their patients. As discussed above, various social factors – the medical professional setting, social roles, and asymmetrical relationships – constrained the participants' discursive practices with the IMG residents displaying linguistic and interactional adeptness working within these professional boundaries.

Here I wish to highlight a few other factors, which may play an influential role on the ways in which the IMG residents enact relational practices. Adding to the social factors noted above is the short-term relationship, which defines the medical encounter, especially for IMG residents. In comparison to other workplace or professional settings in which people have an opportunity to work together and develop relationships over extended periods of time, the medical encounter is defined by short interactions (in terms of time) punctuated by gaps in

interaction over long periods of time. Additionally, abbreviated training periods[37] further limit

the IMG residents' opportunities to establish relations with patients. However, participation in a

residency or fellowship training program involves the opportunity to work with an experienced

attending physician. This experience may provide IMG residents additional learning

opportunities through direct observation, recurrent interaction, and (un)solicited feedback.

Moreover, some attending physicians may serve as an exemplar or role model for "doing good"

relational work. Finally, a revealing finding of these data showed that examples of relational

work occurred primarily with advanced IMG residents, those with three or more years of

residency or fellowship training. In comparison, the IMG resident with one year of residency

training (there was only 1 IMG resident with one year of training) produced fewer examples of

relational work. While this finding may come as little surprise to those who interact frequently

with residents in training, research of this type explicitly reveals what IMG residents do and can

do in interaction with their patients. This finding highlights the importance of time. As IMG

residents continue to exercise and hone their clinical and technical skills, their relational skills

may also develop over time.

To sum up, in this small dataset of 28 transcribed interactions there was surprising

diversity of relational work functions used to both transact the medical business at hand and

attend to the interpersonal side of the IMG resident-patient relationship. The decision to analyze

and interpret the transactional and interpersonal goals achieved through the relational work

functions proved useful for the data revealed that some relational work functioned in expected

and unexpected ways. For instance, the examples of small talk and empathy served the

traditional interpersonal goal as IMG residents and patients deviated from medical, goal-oriented

talk for several turns to attend to the relational side of the interaction. However, some instances

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[37] A typical residency training program is 3-4 years in duration and a typical fellowship entails 1-2 years of training.

of relational work demonstrated that their use worked in multifaceted ways. For example, instead of serving strictly interpersonal goals, both humor extracts demonstrated that humorous enactments can achieve additional goals and functions. In addition, my analysis of the patient education extracts, arguably transaction-oriented discourse, demonstrated how the IMG resident attended to both interpersonal and transactional goals as she provided additional educational information to her patients. Consequently, these few examples highlight the diverse functions and features of relational work and, more importantly, the significance of utilizing a discursive approach to examine relational work in the medical encounter context.

**CHAPTER FIVE: DISCUSSION**

Chapter five is divided into multiple sections to provide concluding thoughts and further discussion about the findings of this research study. In addition, implications related to research on health communication and international medical graduates are addressed. Finally, further study limitations and directions for future research are considered.

**Conclusion and Discussion**

In Chapter four I explored numerous topics on the main subject of giving and receiving of treatment advice during medical encounters. My analysis of the data presented in Chapter four revealed that this medical speech activity embedded within the medical encounter is realized through the use of a variety of discourse strategies and contributions of multiple participants as they attend to the interpersonal and transactional goals associated with the delivery and receipt of treatment advice. A central theme, also highlighted by previous scholars (e.g., Koenig, 2008; Stivers 2005b, 2006), is the negotiated and co-constructed nature of giving and receiving treatment. The analysis presented in Chapter four provides additional support for this previous research finding as it demonstrated the discourse strategies the participants utilized to co-construct, negotiate, and enact treatment advice. In addition to this finding, in the section that follows other significant findings of the research will be presented.

In research question one it was demonstrated how the structure and organization of medical encounters in these data played a consequential role in the way the treatment advice phases were enacted. As the setting for this research study took place in a teaching environment, the medical encounter became segmented into, what I termed, solo and joint interactions. This

type of supervised medical encounter had a significant impact on the length (the average visit

was 28 min. 31 sec.), the structure, the included phases, and ways in which the participants

discursively constructed the phases of the medical encounter.  Specifically regarding the

treatment advice phase, we saw how this became an optional phase during the solo interactions

between IMG residents and patients.  In contrast, the treatment advice phase, when necessary,

was not optional during the joint interactions with attending physicians.

An additional impact of this segmented medical encounter appears to be on the number of

treatment recommendations the patient may receive.  If treatment advice is delivered during the

solo interaction then it is possible the patient will have an opportunity to receive treatment advice

on two occasions.  What ramifications, if any, does this have on the patient?  It would seem that

recommendation alignment or misalignment, in other words if the IMG resident's and attending

physician's treatment recommendations are congruent or not, is an important issue to consider.

For instance, as Extract 4.6 demonstrated there were times when the IMG resident's and

attending physician's recommendations misalign.  This example demonstrated how treatment

recommendation misalignment required the two physicians to negotiate a recommendation with

the IMG resident deferring medical authority to her attending physician.  Misaligned

recommendations resulting in negotiation may have consequences on patient uptake.  In other

words, physicians need to be mindful to take the necessary discursive measures to handle and

mange misaligned recommendations so patients are not left confused but rather fully understand

the final treatment recommendation.

Given the limited control I, as the researcher, had over the participants involved in the

interactions, this research study allowed me the opportunity to explore discourse associated with

multi-party talk.  As mentioned in Chapter four, interaction data that included multiple

participants was an unexpected outcome of this study. Due to the fact interactional research focuses near exclusive attention on dyadic interactions, this research provided important insights into the ways participants in a medical context collaborate, co-construct, and negotiate the multiple phases of the medical encounter. For instance, the data revealed how a patient's advocate can open up the treatment advice phase, how an IMG resident and attending physician can negotiate treatment before settling on their final recommendation, and how a patient's nurse can use small talk to explore the relational side of the interaction. This type of multi-party talk has significant relevance and implications for the study of medical discourse. For instance, how does the patient's advocate contributions of talk support, add, hinder, or confound the unfolding medical encounter interaction? What role does the patient advocate assume: does the role remain constant or does it transform as the phases of medical encounter unfold? How do the concepts of power and authority interplay with the differential roles the IMG resident and attending physician inhabit and affect the ways they interact with each other and the patient? These questions, in addition to those raised below (see "Directions for Future Research" section) are important issues to consider and explore with future research.

In research question one and two I explored how the initiation of the treatment advice phase sequence was developed, specifically examining which participants were responsible for initiating treatment discussions. Previous research has tended to focus primarily on the ways in which advice is delivered, demonstrating that the individual with greater authority or expertise gives advice (DeCapua & Huber, 1995; Heritage & Sefi, 1992; Hutchby, 1995; Locher & Hoffman, 2006). However, as Locher and Limberg (2012) point out, it is necessary to consider the "interactional environment in which advice is introduced" (p. 6). Accordingly, this study adds to the body of literature on advice giving by demonstrating how the initiation of the advice-

giving sequence impacts the unfolding of the sequence and consistently demonstrates the co-constructed and negotiated nature of the speech activity. In this study, various participants initiated the advice-giving sequence. In addition to the IMG residents and attending physicians initiating the advice-giving sequence through the use of declaratives and interrogatives (see further discussion below), these data demonstrated that the patient and patient's advocate also opened up the sequence. Thus, these latter examples showed how the non-expert's initiation created an environment for the co-construction of the treatment recommendation, thus having important implications for future research on the subject of patient participation in the medical encounter.

A particularly significant way interrogatives were used was to solicit input (from the hearer) about the treatment plan. Previous empirical studies exploring advice giving and receiving in various contexts have differentiated between solicited and unsolicited advice (DeCapua & Huber, 1995; Heritage & Sefi, 1992; Leppänen, 1998) examining whether the advice seeker solicited the advice or not. The analysis here provides an expanded or alternative definition of solicited advice showing how the advice giver used various question formulation strategies seeking initial input from the advice seeker prior to delivering the advice. One of the authority figures or experts in the medical encounter interactions, the IMG residents, used this input solicitation strategy; they utilized this strategy during six solo interactions, or in 38% of their advice giving sequences.

Significantly, this approach is associated with the patient-centered model as it directly involves the patient in the treatment decision-making process. Furthermore, the examples of this input solicitation approach served as exemplars of the co-constructed nature of giving and receiving of treatment. Of further significance, the data also demonstrated that the solicitation of

patient input can be a risky move. In some instances patients demonstrated compliance and a willingness to offer opinions and input on their own treatment. However, in other instances the analysis revealed patients used both direct and indirect discourse strategies to demonstrate an unwillingness or reluctance to participate in the treatment decision-making process. Thus, the data suggest that the way the IMG resident formulates the opening solicitation impacts the type of response received by the patient. Vague, non-specific language may lead to confusion or occasion a non-response from the patient. Contrarily, IMG residents' references to specific medication or future course of treatment may prove to be more successful approaches for engaging patients in decision-making.

As noted above, only IMG residents sought patient input as the medical encounter moved into the treatment advice phase. In other words, these data revealed that the attending physicians did not use this discourse strategy in their interactions with patients. What may account for this significant difference in interactional strategies in which one participant group, IMG residents, solicited patient input more than one-third of the time and another participant group, attending physicians, not at all? Factors that may have contributed to the different approaches are: 1) status difference between IMG resident and attending physician, with the IMG resident assuming the novice role and the attending physician assuming the expert role in these interactions; 2) a contemporary approach recently introduced (in medical school or residency training) with which the IMG residents have become more familiar; and 3) the placement of the solicitation strategy during the solo interaction, occurring earlier in the medical encounter. Any of these factors or others may have contributed to the difference in treatment advice giving strategies between IMG residents and attending physicians.

As these data demonstrated, the solicitation of input into the advice-giving sequence occurred in a specific institutional context – the medical encounter. Moreover, a specific type of expert, the IMG resident, was the participant group that utilized this strategy exclusively. However, in other institutional or workplace contexts where collaboration, maintaining harmonious relations, and shared decision-making are valued, the relevance of this research and findings may have broader implications and may be applied to other institutional contexts.

Interrogatives have received considerable attention in the health communication literature but frequently focus on how physicians utilize questions to seek health condition information from patients (Boyd & Heritage, 2006; Heritage & Clayman, 2010; Jones, 2001; Mishler, 1984; Robinson, 2003). Turning the table so to speak, these data demonstrated how patients utilized questions during the medical encounter. In research question three the analysis identified that on certain occasions patients utilized interrogatives to question the physicians about certain aspects of their treatment plan. In some instances patients' interrogatives took a normative approach whereby their questions served to clarify or seek additional information (Street & Millay, 2001; Zhang, 2010). Additionally, other patient interrogatives functioned as a means for demonstrating active participation in the decision-making process. Overall, the analysis revealed the power and potential of interrogative use in the treatment advice phase. IMG residents' interrogatives attempted to invite the patient into the treatment decision-making process and the patients' own use of interrogatives actively embedded them in the decision-making process.

An additional finding from the research questions illustrated that IMG residents utilized indirect, as opposed to direct, treatment advice strategies. Treatment advice was formulated using declaratives but the IMG residents used various discourse strategies (e.g., modalized verbs, *we* pronoun; tag questions) to attenuate the force of the treatment recommendation. This strategy

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is in line with Locher and Limberg (2012) who point out that advice givers "often use mitigation strategies to downtone the impression that they might be imposing their view on the advice-seeker" (p. 6). Further, in comparison to their attending physicians, the IMG residents formulated treatment advice indirectly more frequently.

Finally, as demonstrated by the data in research question four, IMG residents demonstrated their ability to attend to the relational side of interactions with their patients (see "Implications for IMG Residents" section below for further discussion). To demonstrate how these interactions were realized I examined several different examples of relational work (e.g., sarcasm, empathy, patient education, resistance) between IMG residents and patients exploring the ways in which the participants attended to and managed interpersonal relations. Through the examination of different acts of relational work a perspective begins to develop of the norms and practices that define the medical encounter social context. That is to say, through the exploration of how, for instance, humor, small talk, and confrontations get played out in interactions between physicians and patients, we begin to see how institutional practices, social roles, ideologies, and culture define but also constrain the establishment and management of relationships in this medical institutional setting. Thus, as there exists a paucity of research on how relational work is accomplished between physicians and patients this study provides some insights into the interactional and discursive strategies used to negotiate and manage relationships in this brief, often emotionally charged, often intense, and outcome driven medical context.

On the interactant level, we also begin to see how participants attend to each other's face needs as they work to enhance, maintain, or challenge face through the dynamic process of negotiating relationships. Importantly then both IMG residents and patients need to be socialized into the norms and practices that define the medical encounter so that they can discern the impact

of their linguistic choices on interpersonal relations (Locher, 2012). Moreover, as the analyst, I too had to be socialized into medical encounter norms and practices in order to evaluate and ultimately "judge" the patient's and IMG resident's discourse in situ to determine its positive, neutral, or negative influence on face. As Locher (2012) aptly points out the "process of judging" is in need of further theoretical and empirical exploration (p. 54) as this evaluative process proved challenging and laden with incertitude in many instances. By way of explanation, during the analysis it felt like oftentimes if I did not "judge" an interactant's contributions to the interaction sequence to be particularly face-enhancing or face-challenging then I evaluated them as face-maintaining. As these are theoretical issues that require further exploration, I now move to practical implications gleaned from the research.

**Implications for Healthcare Communication**

In this section I consider some aspects at the interlocutor level that have practical implications for healthcare communication. That is to say, some of the practical aspects of the healthcare communication I observed and analyzed are considered with an eye toward useful and meaningful application. Specifically, I explore three areas – active patient participation, the patient advocate benefit, and the attending physician's role as communication teacher – demonstrating the implications on healthcare communication.

During the medical encounter the communicative weight of the interaction is ideally shared equally between patient and physician. From the patient perspective, patients share the communicative load by talking with the physician about general and specific healthcare needs and concerns and, on some occasions, beliefs, fears, and expectations (Street, 2001). As Ranney (1992) tells us, "medical care suffers when patients are unable to convey precise information to

the doctor due to institutional constraints or communication problems" (p. 28). Thus, patients'

participation during the medical encounter is an important part of the healthcare process.

As these data demonstrated patients' interactional participation varied. Demonstrating

active participation, some patients asked questions, others expressed resistance and engaged in

small talk. In comparison and taking a more passive approach, patients responded minimally,

remained silent and sometimes utilized vague or unclear language to describe symptoms,

concerns, or medication dosages. Given that interpersonal communication remains the primary

means through which an exchange of information occurs in the medical encounter, patients'

ability to provide detailed health information is essential.

From a patient education perspective, in order to share the communicative weight and

actively participate patients must be prepared to describe symptoms and conditions in a detailed

manner. This may require some prior preparation on the patients part to think about what is

ailing them, gather records, and maybe rehearse so that communication of symptoms, changes in

symptoms, medications administered occurs in a clear and concise manner. Miscommunication

of symptoms or medication dosages can eat up valuable time during the medical encounter and

more importantly can lead to misunderstanding and potential misdiagnoses. In addition, asking

questions and seeking clarification if directions are unclear or if information is not clearly

understood, is an active participation tool patients should use.

As discussed above, an individual who can aid the patient and share the communicative

load is a patient advocate or caregiver (e.g., spouse, friend, nurse). As demonstrated through

these data, the patient advocate played an influential role during several medical encounters.

These data revealed that the patient advocate helped the patient answer physicians' questions,

answered questions directly, brought an alternative perspective, and served as another "set of

ears" to help patients process the unfolding talk of medical encounters. This last point of serving as an additional "set of ears" is of crucial consideration for all individuals who participate in medical encounters. Technical vocabulary and the rapid pace of medical encounter interactions produce complex and stressful situations for patients. Consequently, an additional individual aiding the patient through the medical encounter can figuratively and perhaps literally be a lifesaver.

Turning to the physician participants in the study, as we saw how IMG residents and attending physicians worked in tandem to share the communicative load of the interactions. For these physician participants each medical encounter served as an educational opportunity as medical, clinical, and technical knowledge and expertise passed from the attending physician to the IMG residents. In addition, this educational environment served as an important arena through which the IMG residents could observe, evaluate, learn from, and potentially imitate the interpersonal skills of the attending physicians. In this way, the attending physicians' interpersonal and communication skills have an impactful role not only on the interactions but also on the development and refinement of the IMG residents' interpersonal skills.

**Implications for IMG Residents**

As Cameron and Williams (1997) state about cross-cultural interactions in medical settings, "there is great potential for miscommunication" (p. 415). While this may be true when speaking in general terms, a close analysis of the cross-cultural interactions presented here demonstrated that instances of miscommunication occurred rarely and were not a major finding of this study. Therefore, as part of the conclusion of this research study it is necessary to address the divergence between anticipated and actual results. Specifically, how do I account for the difference between the anticipated sociopragmatic difficulties I expected to find as the IMG

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residents interacted with their patients and the actual experiences displayed through these data? In other words, why, in this end, is this not a study about second language users' communicative difficulties and language breakdowns?

A review of the literature on IMGs demonstrates that language barriers play a significant role in issues they encounter, leaving them at a communicative disadvantage with their patients and colleagues within the healthcare system (Dorgan et al. 2009; Huijskens, Hooshiaran, Scherpbier & van der Horst, 2010; Jain & Krieger, 2010; McGrath, Henderson & Holewa, 2013). Language and concomitant sociopragmatic issues discussed in the IMG literature include: difficulty understanding IMGs' accents (Jain & Krieger, 2011; McGrath et al., 2013), understanding and using the L2 pronunciation system (Dorgan et al., 2009; Jain & Krieger, 2010), understanding and using L2 colloquialisms (Jain & Krieger, 2011; McGrath et al., 2013), understanding and using paralinguistic cues (Hall et al., 2004; Jain & Krieger, 2010), understanding C2 power dynamics (Dorgan et al., 2009; Erickson & Rittenberg, 1987; Hall et al., 2004; Jain & Krieger, 2010), difficulty establishing rapport with patients (Dorgan et al., 2009; Fiscella & Frankel, 2000), breaking bad news (Cordella & Musgrave, 2009; Hall et al., 2004), and initiating small talk (Jain & Krieger, 2011). Following these findings, I envisioned and proposed to conduct a study with IMG residents as the main participants. I hypothesized that the IMG residents in this study would experience sociopragmatic and pragmalinguistic difficulties interacting with their patients, specifically during the treatment advice phase of the medical encounter. The treatment advice phase is a challenging speech event within the medical encounter, as these data have shown, given the possibility for negotiations to ensue with patients about different treatment options. Consequently, this phase of the medical encounter received primary focus.

However, as demonstrated above and throughout Chapter four, these data demonstrated that the IMG residents' contributions to the medical encounter discourse exhibited a general lack of language and pragmatic competence issues. Below I highlight several features of the IMG residents' discourse, discussed in great detail in Chapter four, as evidence of their linguistic and pragmatic competence in their L2.

Before turning to the evidence, it is important to touch on the methodology used in this study. Given the methodological decision to use naturally-occurring spoken data, these data provided actual evidence from medical encounters interactions to demonstrate the discourse strategies IMG residents used with their patients. This methodological decision lies in contrast to previous studies on IMGs, which primarily utilized interviews, focus groups, and survey data to arrive at findings that create this problematic picture of IMG residents (see Cordella & Musgrave, 2009; Erickson & Rittenberg, 1987 for exceptions). Using these types of methodologies it is possible to gain insights into the study participants' perceptions of problems and barriers that lead to misunderstanding, miscommunication, mistrust and difficulty establishing rapport with patients (Fiscella & Frankel, 2000). Moreover, in an effort to find solutions to problems, studies designed to report attitudes and perceptions focus primarily on barriers and limitations to success as Huijskens et al. (2010) reported in their study. In interviews their IMG participants emphasized barriers as opposed to facilitating factors far more frequently (p. 802). Without actual interactional data with patients or other healthcare members it is difficult to square these perceptions with reality. However, when data analyses rely on actual interactional practices, findings provide different and competing results. Thus, this study makes an important contribution to this body of literature on IMGs by demonstrating what IMG residents are able to actually do both linguistically and pragmatically with their patients.

The study demonstrated that the IMG residents relied predominately on the use of indirect (as opposed to direct) treatment advice giving strategies. Attenuation strategies such as hedges, modalized verbs, and the inclusive *we*, were used to mitigate the forcefulness of their advice. Using such strategies and others to formulate advice indirectly in English requires advanced linguistic and pragmatic knowledge, thus demonstrating that the IMG residents in this study can be considered proficient and competent English users with their patients in this medical context.

Nevertheless, the data showed a few instances of miscommunication. For instance we saw clarification checks used in Extract 4.20 and on other occasions patients misunderstood IMG residents' words. In addition, we saw how an IMG resident's attempt at humor and an attempt to solicit his patient's input about treatment for her headache both backfired requiring additional conversational turns to manage the damage. However, given these examples found in the data it is not possible to solely attribute the miscommunication to L2 usage. Furthermore, these types of miscommunication examples are not prevalent enough to conclude that the L2 played a contributing role.

The IMG residents displayed productive knowledge through their proficient use and understanding of advanced idiomatic expressions. For instance, we saw in Extract 4.14 an IMG resident use *amp up* as a verb to recommend an increase in the patient's medication and the use of the idiomatic expression *I'm not so bottom line* in Extract 4.17 as a way to express uncertainty about a treatment recommendation. While not prevalent in quantity, these few examples illustrate not only linguistic use at an advanced level but also advanced sociopragmatic command. Both idiomatic expressions were appropriately used in this medical context. Additionally, IMG

residents' receptive knowledge was also on display as evinced by their ability to interpret a

patient's use of sarcasm and read into a patient's indirect reference to suicidal thoughts.

In addition to the sociopragmatic use mentioned above, IMG residents utilized additional

strategies demonstrating their knowledge and adeptness to use the L2 in contextually appropriate

ways.  On numerous occasions the data showed that the IMG residents opened up the treatment

advice phase by soliciting input from patients.  Taking this patient-centered approach is arguably

a risky move (see Extract 4.41 for an example) but it was an approach they were willing to take

and execute successfully in many instances.  In addition, when necessary, the IMG residents

negotiated with their attending physicians over the future course of treatment for their patients

(see Extract 4.6).  Arguably, negotiating with a superior can be a face-challenging act but in the

few examples where this negotiation was necessary, the IMG residents used discourse strategies

to discuss the treatment peer-to-peer while attenuating the force of the face-challenging act.

Finally, in Chapter four we saw the multiple ways in which the IMG residents managed

relations with patients.  Arguably using discourse strategies to establish and maintain relations

illustrates additional sociopragmatic skills and command in the L2.  For example, IMG residents

used humor and in one instance learned from a sociopragmatic error (in Extract 4.34) to modify

humorous language usage when it was determined to be a potential mistake.  The example of an

expression of empathy exhibited in Extract 4.37 demonstrated an adept ability to attend to the

face needs of a crying patient with words of comfort and reassurance.  In addition, an IMG

resident was able to take an interpersonal approach while indirectly delivering a treatment

recommendation and providing patient education (in Extract 4.39).  This complex delivery

approach attended to the medical needs of the patient using a range of advanced interpersonal

and linguistic skills in the L2.

Taken together these numerous examples demonstrated that language barriers and concomitant sociopragmatic issues, as frequently discussed in the IMG literature, were not a significant issue in the medical encounter interactions with these IMG residents. The naturally-occurring spoken data revealed that the IMG residents used advanced L2 linguistic formulations to give indirect advice, use idiomatic expressions, and display affect, when necessary, with their patients. Consequently, it is necessary to report when IMG residents make few linguistic, pragmalinguistic, or sociopragmatic mistakes or cause episodes of miscommunication so that a balanced representation of the "state of IMGs" in the U.S. can begin to be created.

**Limitations of Study**

In this concluding section I wish to address some additional methodological limitations of the study. Conducting a research study such as this teaches one a great deal about the research process and oneself. For instance, not until after the study design is devised and the plan implemented can one comprehensively assess the successes and shortcomings of the plan and execution. Here I address two areas of the methodology and make recommendations for modifications to the process.

In the proposed study I anticipated that 40-60 physician-patient interactions would be collected and used to inform the study. During the data collection phase 31 physician-patient interactions were collected. While I regarded the collection of 40-60 interactions to be an ambitious schedule, I also considered the quantity to be both feasible and sufficient. A number of factors contributed to the variance in proposed versus actual number of collected interactions.

Access to the IMG residents, or perceived access as I began to call it, proved to be a main contributing factor. In truth, as a professional member of the community from which the data were collected I envisioned that the recruitment process was going to be easier than in reality it

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turned out to be. As I discussed in Chapter three (see section "My role as Researcher"), I had established an awareness of the insider-outsider roles I inhabited and the privileges and limitations these dual roles brought to the research process. While establishing this awareness prior to implementing the proposed methodology proved insightful and was undoubtedly beneficial, not until one actually puts these roles into action are their true meanings realized. In other words, I learned through this process that there is sometimes a disconnect between the proposed, visualized, or ideal research study and how the researcher anticipates it will go and the actualized study it becomes. For example, a priori suppositions about methodological issues related to participation rates, clinic sites, and length of time needed to collect data became challenges that I faced along the way. As a result, real-time decisions needed to be made that had consequences on the way the study turned out. Below I address some additional issues that contributed to differences between the proposed and actualized study.

I made several decisions about the medical specialties I chose to contact during the recruitment process that served to limit the pool of participants. For instance, the medical specialty criteria[38] I used to recruit IMG resident participants likely played a role in the number of interactions I was able to collect. Loosening these criteria would have resulted in an expanded number of medial specialties I contacted. As a consequence, this expansion may have increased the participation pool resulting in additional interactions. Consequently, if I were to conduct this study again I would continue to use the medical specialty criterion mentioned above (non-surgical specialties in an outpatient setting) but I would eliminate the restriction placed on the number of IMG residents in the residency program. As a result of these selection criteria

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[38] As mentioned in Chapter three, I selected the medical specialties because each residency program had more than one IMG resident in the program. Additionally, I chose to work with medical specialties in which the medial encounter occurred in outpatient as opposed to inpatient settings. Consequently, this decision excluded surgical medical specialties.

modifications it is possible the number of IMG resident participants and interactions would increase.

A second factor relates to the hierarchical nature and structure of residency or fellowship programs, which created barriers to access that I do not foresee upon starting the research study. Given my insider role as a GME administrator, I was aware that a hierarchical structure existed within the residency and fellowship programs and as a result I implemented a recruitment protocol that took this structure into account.  However, despite my best efforts, this hierarchy proved challenging to negotiate and served as a barrier to recruiting as many IMG residents as I would have liked.  Thus, I learned through this process that knowing the right contacts does not ensure success, but rather convincing the contacts, stakeholders, and participants of the value of the research and how it could be used to benefit the program and participants is a crucial element. As a consequence of this learning experience, I have come to understand there is no getting around the structure that exists to protect residents and fellows; consequently, persistence, patience, and stressing the importance of the research are contributing factors to success.

It is certainly possible I could have remained in the field longer to collect the proposed number of interactions.  However, one year in the field seemed to be a sufficient period of time for this research study, which itself has its own time restrictions.  Therefore, while staying in the field may have yielded additional interaction data, I have concluded that the 31 interactions I did collect provided sufficient data to answer the four research questions.

The second methodological issue I wish to address relates to the post-medical encounter patient survey.   There are two factors that require examination as they contributed to a less than successful implementation and use of the survey instrument.  Additionally, I wish to address my decision to selectively use the survey data.

As mentioned in Chapter three, the survey completion rate was 68%. Contributing to this lower than expected completion rate was an inconsistent distribution of the survey with several factors contributing to this inconsistency. On a few occasions patients were unwilling to complete the survey. In other instances, logistics inhibited my ability to give the patient the survey because we were in two different physical locations (different examination rooms) at the completion of the medical encounter. Additionally, there were several instances when I determined the patient had already spent considerable time at clinic, was not in a good emotional state at the conclusion of the interaction, or was in a hurry to leave to complete lab work. Therefore, I made a determination in these instances not to further impose on the patients, requesting additional time to complete the survey. Importantly, my own judgment about the patient's disposition at the end of the medical encounter impacted this decision not to ask the patient to participate in the survey. It was this last factor that accounted for the majority of missed opportunities to collect survey data. Consequently, given these perceived and real difficulties to consistently collect survey data requires, in retrospect, a reconsideration of the methodological decision to complete the survey at the end of the medical encounter. Perhaps an alternative approach, such as involving a clinic staff member like the nurse, would have resulted in a more consistent distribution of the patient survey. Consequently, if I were to conduct a similar study again using a patient survey, I would attempt to implement this alternative approach and ask a staff nurse to administer the patient survey on my behalf.

A second factor contributing to the less than successful implementation of the survey instrument related to how the patients answered some of the survey questions. That is to say, as the analyst it was difficult to determine with certainty that the answers the patients provided were about the IMG residents, the study participants, and not the attending physicians. Seven survey

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questions asked the patient to respond to questions about the doctor. For instance, question three asked: "In your office visit today, did the doctor offer you any treatment?" or question eight asked: "Did the doctor ask you if you understood the treatment?" Given the general descriptor "doctor" used in these questions and throughout the survey, it was likely unclear to the patient to which doctor the survey question was referring. On occasion, prior to completing the survey, I instructed patients to respond to the survey questions with the IMG resident in mind, not the attending physician. However, I utilized this directive with limited consistency. Therefore, as a consequence of these design and implementation flaws (i.e., inconsistent instructions, general "doctor" descriptor) the survey results were impacted, resulting in an unclear interpretation of these seven questions. This experience highlights the importance of detailed planning required of the survey design and implementation process in order to mitigate issues, ground the interpretive process, and help ensure credible results. Moreover, this process could have benefited from a pilot test of the patient survey so that these issues could have been discovered and addressed ahead of full implementation.

These contributing factors in addition to other reasons that will be explored here impacted my decision to use only a portion of the survey data. As seen in Chapter four during the analysis of research question three, I utilized responses to questions four and nine to aid in my determination of the patients' expressed likelihood to follow treatment recommendations. No other survey responses, except in Extract 4.41, were used to aid my analysis of other extracts or used as an additional data source to answer the other three research questions. It became my determination that the interaction data, the primary data source for the study, coupled with my observations, served as sufficiently rich data sources. As evidenced by the 45 extracts presented

in Chapter three, the interaction and observation data served as sufficient evidence on its own to answer the four research questions.

Upon completing the analysis of the 21 completed surveys it became my determination that the responses did not add to or further bolster the arguments being made through the interaction and observation data.  For example, in questions five through eight in which the patients were asked whether they had questions about the treatment or if the treatment was explained clearly, the patients answered affirmatively.   In other words, the results indicated that the patients thought the treatment recommendations were explained clearly and they were able to ask questions about the treatment and indicated they did so during the interaction.  The purpose of these questions was to evaluate the patients' perspectives on the flow of information about treatment.  In other words, the responses were to answer the questions:  did the patients believe they had an opportunity to ask questions about treatment, if so, were they answered, and, in the end, did the patients feel they understood what treatment was being prescribed.  Collectively, these positive responses portrayed the flow of treatment information between patients and physicians as favorable, suggesting that the patients did not experience any comprehension, clarity, or misinterpretation issues during the treatment advice phase.

Examining another question from the survey, question ten, the purpose of this question was to gauge the patients' perceptions of the relations established between the physician(s) and themselves.[39]  Further, I intended to use the responses to question ten during the analysis of research question four.  In this way, the survey results could be utilized to support my analysis and interpretations of the interaction data.  In the 21 surveys, 18 (86%) patients responded "friendly", "courteous", or "polite", and in the majority of the cases selected all three choices to

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[39] Question ten asked:  "In comparison to other doctor's visits you have had in the past, use the descriptions below to describe your relations with your doctor today?"  The patients could select from the following descriptors:  average, combative, courteous, disrespectful, friendly, polite, rude, and unexceptional.

answer question ten.  In two surveys the patients responded "average" and in one instance, as noted during my analysis of Extract 4.41, the patient responded "combative".  Consequently, given the lack of variability in the responses, despite eight different choices, I determined that question ten did not significantly support or contradict the interpretations I was drawing from the interaction and observation data to answer research question four.

In conclusion and despite my rationale made here not to significantly use the survey data in this study, I do attach considerable weight to the value gained from seeking patients' perceptions and attitudes through a survey instrument.  As a part of patient-centered medicine where patient participation continues to be sought and valued during decision-making in the medical encounter, the same must hold true as a part of the research process.  In other words, if patient centeredness is to continue to remain the gold standard of the art and science of medicine then patients' voices and input must also inform medical research.  With that said, this research study has demonstrated that the methodological decisions made a priori, while deemed sound at the time, do not always yield useful data which can be utilized to inform the study.  Therefore, as a researcher decisions must be made during the analysis stage to determine which data will serve as the most effectual sources to answer the research questions and make a convincing argument.

**Directions for Future Research**

As this chapter of the research study comes to a close it is necessary to consider how these data and interpretations may contribute to existing research strands and may be used to explore other areas of research in the future.  Examined from a different theoretical or interpretative point of view, these data may provide additional fruitful insights about the ways in which physicians and patients use the language of negotiation to co-construct treatment decisions and the discursive means used to manage their relationships during the medical encounter.

Using these interaction data as a rich resource, in this final section I explore some of ideas, questions and avenues to explore for future research.

As previously discussed, the IMG residents used distinctive discourse strategies during the treatment advice phase to give and solicit treatment advice. While we saw through various examples how the attending physicians recommended treatment advice to patients, this was not a main theme explored in the dissertation. Taking a comparative approach, future research could explore the ways in which IMG residents' treatment advice formulations compare to the attending physicians' formulations. What forms do the different physicians use? For instance, as noted above, the IMG residents took a more patient-centered approach through their solicitation of input from patients. The attending physicians did not use this strategy. What strategy did attending physicians use? In addition, this topic could be explored through the lens of language of expert (attending physician) versus language of novice (IMG resident). What effect, if any, do the different formulations have on treatment decisions and outcomes?

From a discourse analytic perspective, the notions of framing and footing could serve as a framework and provide useful analytical devices through which these data could be fruitfully examined. Here I will only provide a brief description of frames and footing. Building on the works of Bateson (1972), Goffman (1974, 1981) and others, Tannen and Wallat (1987) state that the "interactive notion of frame refers to a definition of what is going on in interaction, without which no utterance (or movement or gesture) could be interpreted" (p. 206). Framing and viewing social interactions through frames help us to "interpret or disambiguate each other's behavior. In order to interpret a given utterance…we must 'know' what frame it is performed in" (Jaworski, 1998, p. 100). Importantly, frames shape and are shaped by both verbal and non-verbal interactions and ones interpretation of a frame is shaped through and by different

worldviews, cultures, and values (Jaworksi, 1998, Tannen & Wallat, 1987).  Goffman's (1981) notion of footing refers to the alignment, stance or posture we take up to ourselves and other participants within an interaction.  Footing and shifts in footing or alignment aid analytic understanding of how frames are managed, negotiated, and potentially reframed between interlocutors.

Following empirical research from Tannen and Wallat (1987), Coupland et al. (1994), Riberiro (1996), and Buchbinder (2008), which utilized the notions of framing and footing to explore discourse in medical encounter contexts, these data could be examined using similar discourse analytic techniques.  For example, in Extract 4.11 we saw how the treatment advice phase shifted between medical and personal frames through contributory turns of talk by the nurse.  What purpose, if any, did the shift to the personal frame serve and were there any consequences to this reframing?  Who, and through which discourse strategies, managed to reframe the interaction back to the medical in order to continue the treatment advice phase?  In addition to shifts in and out of personal and medical frames, these data demonstrated that at times the physicians' discourse shifted between strictly technical talk (between attending physician and IMG resident) and medical talk involving the patient.  As these interactions occurred in a clinical teaching environment, it may be interesting to explore how the technical talk between the attending physician and IMG resident served different goals.  Did the technical discourse serve an educational goal (for the IMG resident) or purely as a transactional goal?  What footings did each participant take up to negotiate this technical frame and how did the participants manage the shift into and out of the different frames involving (or silencing) the patient?  Examining the treatment advice phase through the notion of interactive framing and

footing may provide fruitful insights into how the medical and lay participants manage and negotiate treatment decisions.

With the advent of the patient-centered approach in healthcare, there has been growing interest in understanding the ways in which patients actively participate in and influence decision-making during the medical encounter. One of the forms that this active participation can take is patient resistance. As explored in Chapter four, the language of resistance served a powerful transactional goal as patients expressed dispreference for certain courses of treatment or medication. The data demonstrated that patients used a variety of discourse strategies and resources, which, in some instances, led to extensive physician-patient negotiations, ultimately affecting treatment outcomes.

The data analysis also revealed that the nature of the actual treatment prescribed played an important role in patients' displays of resistance. An interesting phenomenon found in these data is that in particular and more than any other medication, patients expressed resistance to the medication Prednisone. In six, or 21%, of the interactions, the medication Prednisone became a topic of conversation. According to MedlinePlus, an online service of the National Institute of Health, Prednisone is "in a class of medications called corticosteroids. It works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. Prednisone works to treat other conditions by reducing swelling and redness and by changing the way the immune system works" ("Prednisone", 2010). Prednisone is a contentious medication due to the harmful (e.g., osteoporosis, weakened immune system, elevated blood sugar, eye changes) and unpleasant (e.g., weight gain, digestive upset, skin problems) side effects experienced in individuals who take high doses and for an extended period of time.

Based on these interaction data I discovered patients have strong opinions about the medication that they are willing to share with their physicians. In some instances, patients expressed that they did not mind taking Prednisone but in other instances patients expressed resistance to starting or continuing to take it. In one particularly descriptive example in the data, a patient's discourse exhibits compliance and agreement about one class of medications and noncompliance or resistant to another type of medication, in this case Prednisone, during the treatment advice phase (in the joint interaction). Interestingly, the more conflictual exchange between patient and physician about the Prednisone medication occurs immediately following the harmonious exchange about another medication. Thus, this interaction illustrates how treatment advice for particular classes of medication may lead to expressions of resistance from patients. Future research on this topic may attempt to answer such questions as: What forms do patients use to express their resistance? How do physicians discursively manage the resistance? How do patients and physicians enact and manage their social roles during these episodes of resistance? What is the interplay between power and authority and patients' expression of resistance? How does the treatment advice phase conclude and what is the resultant treatment outcome?

Turning to an alternative theme, future research could continue exploration of multi-party talk, its co-constructive nature, and influence on the unfolding of the medical encounter interaction in general and the treatment advice phase specifically. Various participants contributed to the medical encounter conversation but as these data demonstrated the patient advocate or caregiver assumed an influential role and impacted the interactional outcomes in various ways. Hasselkus (1992) argued caregivers can assume three different roles – facilitator, intermediary, and direct source – with each role utilizing a different discursive strategy (p. 292).

With this adoption of different roles on behalf of the patient and within medical encounter interactions, physicians and other healthcare workers need to be mindful of the status of the patient advocate and the impact he or she can have on interactions (Lu & Corbett, 2012).

While multi-party talk can serve a collaborative function it can also serve to silence some participants in the conversation. These interaction data suggest that multiple participants, including the patient advocate, may influence patient participation and in extreme cases have a silencing influence on patients. For example, when talk is concentrated exclusively on the medical domain and occurs solely between medical professionals, this can limit patients' opportunities to participate and potentially serve to exclude and silence them. Moreover, as Hasselkus (1992) suggests patient advocates can assume the role of "direct source" (p. 292) of information in the medical encounter interaction. In these cases the patient advocate "speaks *for* the patient *about* the patient's health and health care, that is interpreting the patient's case to the physician" (p. 291, italics in the original). These cases shift the interaction from triadic to dyadic and work to exclude the patient's voice in the process. Following Hasselkus (1992), this may be a productive avenue of research to explore examining the ways in which multi-party discourse serves to exclude and silence patients and ways in which the patients manage the situation.

This study has demonstrated how treatment advice is delivered and received through the use of a variety of discourse strategies and contributions of multiple participants. Importantly, as a discourse analytic study, it examined the language used during this phase of the medical encounter and while providing many fruitful insights it left some questions unanswered for future exploration. For instance, in a teaching environment what discourse strategies do attending physicians and residents use to negotiate a treatment decision? Does it always occur in the front stage, in the examination room, or does it sometimes occur in the back stage of a

physician's office?  What affect do these different strategies have on patient's uptake and

compliance with treatment recommendations?  How do the different interpersonal and

communication skills, behaviors, and personalities of attending physicians affect the experiences

of residents, especially IMG residents?  What additional learning affordances can be distilled

from this teacher-learner relationship in the outpatient clinical setting?  While these questions

represent just a few of the interesting areas requiring future exploration, with practical

implications for medical education, they are questions to be explored in future research.

However, such questions imply that a great deal of important research remains on the treatment

advice phase and the ways in which it is negotiated between residents, attending physicians, and

patients.

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# APPENDICES

<u>**REQUEST FOR PARTICIPATION**</u>

USF Study ID: Pro00011036

TGH Study ID: FWA 00001442

<u>**Research study title:**</u>

A study of pragmatic competence: International medical graduates' and patients' negotiation of the treatment phase of medical encounters.

<u>**Principal Investigator:**</u>  Amy Fioramonte ([afioramo@health.usf.edu](afioramo@health.usf.edu))

<u>**Research study purpose:**</u>

This study addresses the important but often neglected topic of International Medical Graduate (IMG) residents and fellows. IMG residents represent over 160 different countries in the U.S. with diverse sociocultural backgrounds (Educational Commission of Foreign Medical Graduates Annual Report, 2010). Therefore, it is likely that their diverse sociocultural backgrounds will impact ways in which IMG residents view and conduct interactions with patients. Research indicates that some IMG residents experience difficulties adapting to the ways in which physician-patient interactions are conducted in the U.S. (Dorgan, Lang, Floyd, & Kemp, 2009; Hall, Keely, Dojeiji, Byszewski, & Marks, 2004). For example, some IMG residents have reported difficulties delivering diagnosis and treatment advice directly to the patient due to the fact that from their cultural perspective this news should be delivered to a family member (Hall et al., 2004; Jain & Krieger, 2011). However, little is known about how IMG residents actually go about conducting interactions with patients.

Taking a qualitative approach, this research study will provide evidence into how IMG residents conduct interactions with patients by examining the spoken interactions of the treatment advice phase of the medical encounter. The study examines the language and linguistic strategies IMG residents and patients use to jointly construct and negotiate the treatment advice phase of the medical encounter. The treatment advice phase receives primary focus because I hypothesize this phase of the medical encounter entails more than simply disseminating treatment advice and information; rather, it entails taking patients' viewpoints and opinions into consideration so that an agreement can be reached regarding patients' treatment plans. Moreover, if IMG residents cannot effectively communicate their treatment recommendation to patients, then patients may be less likely to comply, potentially putting their health at risk. Consequently, conducting research into how IMG residents go about making treatment advice to patients can provide needed insights, which may lead to better doctoring practices overall and the development of curriculum and educational programs designed to address the specific issues IMG residents face.

This research study is being conducted as a part of the PI's partial fulfillment of requirements for a Ph.D. degree at the University of South Florida.

## Participants:

I am seeking participation from International Medical Graduate residents or fellows who meet the following inclusion criteria:

1. Graduated from a medical school outside the U.S.
2. Native language is something other than English

## Method:

Data collection procedure:  I will observe and audio record 8-12 medical encounters between IMG residents/fellows and patients.  Patients' informed consent will be sought.

Where:  USF Health or TGH outpatient clinics

When:  Data will be collected while the IMG resident/fellow is working in an outpatient clinic. Data collection periods will be scheduled with the IMG resident/fellow but I propose collecting data during two different 2-hour intervals.  The IMG resident's total time commitment will be approximately 4 hour, occurring during periods of time when the IMG resident is normally seeing patients.

## Participation benefits and risks:

As a benefit and token of appreciation, an honorarium – a $50 gift card to a local or national retailer or in kind honorarium – will be given to each IMG resident/fellow who participates. This honorarium will be given at the end of data collection phase.

There are no anticipated risks to participants who chose to participate in the study.  Participants' identity will be protected to the fullest extent possible throughout the research period and thereafter should the research be published.  Any information obtained in connection with the study will remain confidential and will be disclosed only with participants' explicit permission.

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# Appendix B:  IRB Approval Letter

February 5, 2013


Amy Fioramonte, M.A.
Secondary Education
12901 Bruce B. Downs Blvd.
Tampa, FL  33612


RE:  **Expedited Approval** for Initial Review
     IRB#: Pro00011036
     Title:  A study of pragmatic competence: International medical graduates' and patients'
        negotiation of the treatment phase of medical encounters

Dear Ms. Fioramonte:

On 2/4/2013 the Institutional Review Board (IRB) reviewed and **APPROVED** the above
referenced protocol**.** Please note that your approval for this study will expire on 2/4/2014.

Approved Items:
**Protocol Document:**
Protocol


**Consent Documents**:
Informed consent form for IMG residents.pdf
Informed consent form for patients.pdf
**Please use only the official, IRB- stamped consent document(s) found under the
"Attachment Tab" in the recruitment of participants.**  Please note that these documents are
only valid during the approval period indicated on the stamped document.

It was the determination of the IRB that your study qualified for expedited review which
includes activities that (1) present no more than minimal risk to human subjects, and (2) involve
only procedures listed in one or more of the categories outlined below. The IRB may review
research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR
56.110. The research proposed in this study is categorized under the following expedited review
categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to,

research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John A. Schinka, Ph.D., Chairperson
USF Institutional Review Board

**Appendix C:  Post-Medical Encounter Patient Survey**

Instructions:  Please complete this survey as completely as possible after your visit with the doctor today.

**The survey results will be kept confidential.  The results will NOT be shared with your doctor.**

<table>
<tr><td colspan="5" align="center"><b>Post-Medical Encounter Patient Survey</b></td></tr>
<tr><td>1</td><td colspan="2">Have you seen this doctor before today?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>2</td><td colspan="2">If yes, approximately how many times have you seen this doctor?</td><td></td><td></td></tr>
<tr><td>3</td><td colspan="2">In your office visit today, did the doctor offer you any treatment?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>4</td><td colspan="4">If yes, can you please describe, as completely as possible, the treatment the doctor recommended?</td></tr>
<tr><td>5</td><td colspan="2">Did you have any questions about the treatment the doctor recommended?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>6</td><td colspan="2">If answer to question #5 is YES, did you ask questions about the treatment?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>7</td><td colspan="2">Was the treatment explained clearly?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>8</td><td colspan="2">Did the doctor ask you if you understood the treatment?</td><td>□    Yes</td><td>□    No</td></tr>
<tr><td>9</td><td colspan="4">How likely are you willing to follow the doctor's recommended treatment?</td></tr>
<tr><td></td><td colspan="2">□  Very likely<br><br>□  Likely<br><br>□  Unsure</td><td colspan="2">□  Unlikely<br><br>□  Very unlikely</td></tr>
<tr><td>10</td><td colspan="4">In comparison to other doctor's visits you have had in the past, use the descriptions below to describe your relations with your doctor today? (Select as many descriptors as you wish).</td></tr>
<tr><td></td><td colspan="2">□  Average<br><br>□  Combative</td><td colspan="2">□  Friendly<br><br>□  Polite</td></tr>
</table>

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| | | |
|---|---|---|
| | □ Courteous | □ Rude |
| | □ Disrespectful | □ Unexceptional |
| 11 | Anything else you would like to share about your visit today? | |
| 12 | What is your age? | |
| | □ 18-29 years old | □ 50-59 years old |
| | □ 30-39 years old | □ 60-69 years old |
| | □ 40-49 years old | □ 70+ years old |

| | | | |
|---|---|---|---|
| 13 | What is your gender? | □ Male | □ Female |
| 14 | Is English the primary language you use every day? | □ Yes | □ No |
| 15 | What other language(s), if any, do you use? | | |

| | | |
|---|---|---|
| 16 | What is the highest level of education you have completed? | |
| | □ Less than High School | □ 4-year college degree (Bachelor's) |
| | □ High School diploma or equivalent | □ Master's degree |
| | □ Technical/Vocational education | □ Doctoral degree |
| | □ Some college | □ Professional degree (M.D., J.D.) |
| | □ 2-year college degree (Associate) | |

| | | | |
|---|---|---|---|
| 17 | What is your occupation? | | |
| 18 | Would you describe yourself as Hispanic or Latino? | □ Yes | □ No |

| | | |
|---|---|---|
| 19 | How do you describe yourself? | |
| | □ American Indian or Alaska Native | □ White |
| | □ Hawaiian or Other Pacific Islander | □ Other |
| | □ Asian or Asian American | □ Black or African American |

*- Thank you for your participation -*

**Appendix D:  Observation Notes form**

<div align="center"><strong>OBSERVATION NOTES</strong></div>

Interaction #:

Date:

| **Physical position** |
| --- |
| Resident: <br><br><br> Patient: <br><br> |
| **Facial expression** |
| Resident: <br><br><br> Patient: <br><br><br><br> |
| **Gaze** |
| Resident: <br><br> Patient: <br><br> |
| **Gesture** |
| Resident: <br><br> Patient: <br><br><br> |

Other observations:

**Appendix E:  Transcription Conventions**


| Convention | Description |
|---|---|
| : | Colon indicates an elongated sound or syllable.  Multiple colons are used to indicate a prolonged elongation. |
| Underline | Underlined word indicates emphatic stress |
| ? | Question mark indicates rising intonation |
| **BOLD** | Bolded words indicate key lines |
| CAPS | Capital letters indicate an utterance that is spoken much louder than the surround talk |
| = | Equal sign indicates latching |
| [ | Left-hand bracket indicates the beginning of an overlapping utterance |
| ] | Right-hand bracket indicates the ending of an overlapping utterance |
| (( )) | Paralinguistic features are enclosed in double parentheses |
| ( ) | Items enclosed in single parentheses indicate transcriptionist doubt |
| (#.#) | Pauses >= 0.5 seconds or longer are enclosed in parentheses and the approximate pause length is noted. |
| - | A dash indicates a sharp cut-off |
| (h) | (h) indicates that a word has laughter bubbling within it |
| >word< | Inward arrows indicate faster speech |
| <word> | Outward arrows indicate slower speech |
| $^O$word$^O$ | Words between degree signs are quieter than surrounding talk |

**Appendix F:  Glossary of Medications**

Alprazolam–is a generic name.  U.S. brand names are:  ALPRAZolam Intensol, ALPRAZolam XR, Niravam, Xanax, and Xanax XR.  It is used to treat anxiety and panic attacks.

Amitriptyline–is a generic and U.S. brand name.  It is an antidepressant used to treat low mood (depression) and it may be given for other reasons.

Arava–is a U.S. brand name for Leflunomide.  It is used to treat rheumatoid arthritis.

CellCept–is a U.S. brand name for Mycophenolate.  It is an immunosuppressant used to keep the body from harming the organ after an organ transplant and it may be given for other reasons.

Enbrel–is a U.S. brand name for Etanercept.  It is used to treat rheumatoid arthritis, juvenile arthritis, psoriatic arthritis, ankylosing spondylitis, and very bad psoriasis.

Dapsone–is a generic name.  A U.S. brand name is Aczone.  It is a topical skin product used to treat acne and other skin disorders.

Doxepin–is a generic name.  A U.S. brand name is Silenor.  It is an antidepressant used to treat low mood (depression), anxiety, sleep problems, and it may be given for other reasons.

Gabapentin–is a generic name.  U.S. brand names are:  Gralise, Gralise Starter, and Neurontin.  It is used to treat seizures, painful nerve diseases, and it may be given for other reasons.

Humira–is a U.S. brand name for Adalimumab.  It is used to treat rheumatoid arthritis, psoriatic arthritis, Crohn's disease, ankylosing spondylitis, psoriasis, ulcerative colitis, and juvenile arthritis.

Hydralazine–is a generic name.  U.S. brand names are:  Apo-Hydralazine, Apresoline, Novo-Hylazin, and Nu-Hydral.  It is an antihypertensive used to treat high blood pressure and it may be given for other reasons.

Imitrex–is a U.S. brand name for SUMAtriptan.  It is an antimigraine agent used to treat migraine headaches and cluster headaches.

Keppra–is a U.S. brand name for LevETIRAcetam.  It is used to treat seizures and it may be given for other reasons.

Leflunomide–is a generic name.  A U.S. brand name is Arava.  It is used to treat rheumatoid arthritis.

Maxalt–is a U.S. brand name for Rizatriptan.  It is an antimigraine agent used to treat migraine headaches.

Meloxicam–is a generic and U.S. brand name. It is a nonsteroidal anti-inflammatory drug (NSAID) used to treat arthritis and it may be given for other reasons.

Methotrexate–is a generic name. U.S. brand names are: Otrexup, Rasuvo, Rheumatrex and Trexall. It is used to treat rheumatoid arthritis, cancer, psoriasis, and it may be given for other reasons.

Morphine–is a generic name. U.S. brand names are: Astramorph, AVINza, Duramorph, Infumorph 200, Infumorph 500, Kadian, and MS Contin. It is an analgesic used to ease pain. Neurontin–is a U.S. brand name for Gabapentin. It is used to treat seizures, painful nerve diseases, and it may be given for other reasons.

Oxycodone–is a generic name. U.S. brand names are: Oxecta [DSC], OxyCONTIN, and Roxicodone. It is an analgesic used to ease pain.

Plaquenil–is a U.S. brand name for Hydroxychloroquine. It is used to treat or prevent malaria, treat lupus, and treat rheumatoid arthritis.

Prednisone–is a generic name. U.S. brand names are: PredniSONE Intensol and Rayos. It is a corticosteroid used for many health problems like allergy signs, asthma, adrenal gland problems, blood problems, skin rashes, or inflammation.

Rebif–is a U.S. brand name for Interferon Beta-1a. It is an Interferon used to treat multiple sclerosis (MS).

Remicade–is a U.S. brand name for InFLIXimab. It is used with Methotrexate to prevent more problems in patients with moderate to very bad rheumatoid arthritis. It is also used to treat Crohn's disease, psoriatic arthritis, very bad psoriasis, ankylosing spondylitis, and ulcerative colitis.

Sulfasalazine–is a generic name. U.S. brand names are: Azulfidine, Azulfidine EN-tabs, Sulfazine, and Sulfazine EC. It is used to treat rheumatoid arthritis, ulcerative colitis, and it may be given for other reasons.

Topamax–is a U.S. brand name for Topiramate. It is an anticonvulsant used to treat seizures, prevent migraine headaches, and it may be given for other reasons.

Zoloft–is a U.S. brand name for Sertraline. It is an antidepressant used to treat low mood (depression), obsessive-compulsive problems, panic attacks, post-traumatic stress, mood problems caused by monthly periods, social anxiety problems, and may be given for other reasons.

*Source: Lexicomp*