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Patient engagement and the epistemics of medical authority:

Diagnosis resistance in US primary care

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

Amanda McArthur Hernandez

2021

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ABSTRACT OF THE DISSERTATION

Patient engagement and the epistemics of medical authority:

Diagnosis resistance in US primary care

by

Amanda McArthur Hernandez

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2021

Professor John Heritage, Chair

When patients visit their primary care physician with some new health concern, they bring along their own ideas or worries about what might be wrong and expectations for how the visit might go. Patients are more engaged in their healthcare than ever before, and patient-centered care advocates have long emphasized the importance of pursuing and addressing the patient perspective. Yet in clinical encounters, both patients and physicians maintain an orientation to the physician's medical authority and the primacy of the biomedical perspective. Patients often feel unheard, and their concerns remain unmet. This may at least partially be due to the interactional structure of primary care encounters, which is shaped by a legacy of medical paternalism. When patients have lingering concerns after a physician has assessed their condition, they have limited interactional opportunities for raising those concerns.

In this dissertation, I use conversation analysis and recordings of primary care visits to examine diagnosis resistance, one resource patients use to raise concerns about the fit between a

physician's assessment of their condition and their own experience or expectations. I find that patients resist more often than previously thought, especially when the physician's assessment of their problem diverges from their own. But patients resist carefully, relying primarily on actions that present the least overt threat to the physician's medical authority. In turn, physicians tend to respond in ways that prioritize their own agenda over attending to or pursuing patient concerns. This is made easier by the fact that patients resist in the least overt ways to begin with.

These findings suggest a tension between patient engagement and a legacy of medical paternalism. Patients are working to get their concerns addressed, but are undermining their own efforts by strongly deferring to the physician's authority to assess their problem in the first place. In order for healthcare to more adequately attend to, respect, and treat as central the patient's perspective, more work is needed to find ways for practices like pursuing and attending to the patient's perspective to become a clinical reality, rather than the aspiration they currently are.

The dissertation of Amanda McArthur Hernandez is approved.

Chloe E. Bird

Tanya Jean Stivers

Stefan Timmermans

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2021

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I can’t imagine having wound up doing anything other than conversation analysis. This method has revealed exactly what I love about language – that it’s malleable, locally emergent, a tool people use to get things done in their everyday lives; and that it’s precisely in the blurry areas between categories of practices, norms or “language rules” that people get the most interesting things done, often in somewhat covert ways, and shape the structure of our society as they do it. Conversation analysis is hard – *really* hard for someone so naturally drawn to neat categories – and yet (or perhaps because of this) it’s the only thing that could have held my interest for these seven years, and wherever else my journey will take me. UCLA Sociology is one of the only places – in my mind, the best one – I could have pursued this, as so much of what conversation analysis has to

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CHAPTER 1:

Introduction

1.1 INTRODUCTION

Consider this: You've experienced some new symptom(s) for some amount of time – perhaps serious, alarming, uncomfortable, perplexing – and you're beginning to wonder: should I be worried? Will things get worse? Am I doing the right things to treat this? You've finally decided to see your primary care physician, rearranged your schedule and waited for your appointment. Now you're in the doctor's office for what you know is a short amount of time. You present your problem, and as the visit proceeds, you start to get some ideas about how the physician is understanding the problem, how extensively (or not) they think it needs to be investigated, and how they will advise managing it. Something begins to feel off – maybe the diagnosis doesn't line up with your experience of your symptoms, or the physician didn't ask about your symptoms at all; maybe you were hoping for a referral to a specialist and the physician is pushing back; or the physician is moving toward treating a problem you don't *want* to treat, you just want to know what it is. But the physician has made up their mind about how to address the problem, and the visit is moving toward closing. If your concerns are not addressed, you'll be back at square one when you leave. How might you go about voicing your concerns *now* before the visit ends? Can you do so without coming off as combative or distrustful? How would you get the floor to do that in the first place, without interrupting what the physician is doing? And is there even time for that?

When primary care patients resist a physician's assessment of their problem, it presents its own set of problems for the physician. There may be the obvious issue that the patient wants something that may not be indicated by clinical guidelines, medical training, or the physician's experience in the field. But the difficulties of this moment are also social and interactional rather

than clinical *per se*. For one, patient resistance presents a challenge to physicians' medical expertise and authority, and risks undermining the nature and purpose of the visit – for a patient to seek help from a clinician, who will use their expertise and authority to resolve a problem the patient cannot resolve themselves. Moreover, diagnosis resistance presents a tangibly difficult moment in interactional terms – physicians may have other patients waiting and are likely already running behind schedule from spending more time than they've been allotted with other patients. They've already done the work to assess and address this patient's condition, but here they are toward the end of the visit, and the patient is putting up a kind of interactional roadblock to closing. How do they deal with this?

A common idiomatic expression in American English provides an apt analogy for this situation. "The train has left the station" is used to describe scenarios where some process is underway and one no longer has a chance to influence how it will unfold. This is the situation patients may find themselves in when they have concerns about how their problem is being addressed, but the physician has already assessed the problem and the visit is moving toward closing. Whereas patients have normative opportunities to describe their problem and influence the physician's diagnostic reasoning in the beginnings of visits, at some point the physician has ostensibly made a decision about the nature of the patient's problem and how best to address it, and has shifted into explaining, advising, making plans and otherwise counseling patients before closing the visit. The patient no longer has legitimate grounds for raising lingering concerns without being heard to challenge the physician's decisions.

The reason this idiomatic expression is such an apt analogy for this situation is that its literal meaning – that a train has pulled out of the station and is on its way to a particular location regardless of its passengers' preferences – is also a useful metaphor for the progression of clinical visits once a physician has assessed the situation and begun moving through counseling toward

closing. The tracks here are the clinical interaction and its normative phase structure. The train represents the current moment in a specific clinical encounter. The physician is the conductor, who is not only in charge of the movements of the train, but also represents the institutional authority shaping the range of allowable movements. The patient is a passenger on the train and has neither the rights nor the normative opportunity space to influence the movements of the train.

This analogy highlights two contextual factors that are at play when patients resist a physician's assessment of their condition: the status of medical authority in society and the norms of interaction in this institutional context. Indeed, the difficulty this moment presents for both patients and physicians, and part of the reason it is so difficult to begin with, lies at the intersection of these. Clinical encounters with patients are a key site where medical authority in society is expressed. This relationship is a reflexive one – the status and nature of medical authority in society *shapes* the norms of interaction in this institutional context. Conversely, the ways clinical encounters unfold not only *reflect* the status and nature of medical authority in society, they in turn *enact* it. In the remainder of this introductory chapter, I delve into more background on the intersecting roles medical authority and interactional norms play when patients resist a physician's assessment. In the analytical chapters that make up the body of this dissertation, I examine how resistance plays out in actual clinical encounters, taking a sociological and conversation analytic approach to examining how patients resist primary care physicians' diagnostic assessments, how physicians respond, and the contexts leading up to resistance. In these chapters I consider how medical authority shapes and is reflected in the interactional particulars of this moment. In the concluding chapter I revisit the findings from these chapters, with a focus on not only what they mean for conversation analysis and healthcare communication, but also what they can tell us about the state of medical authority in society.

1.2 CONCEPTUAL BACKGROUND

1.2.1 *Medical Authority in Society*

In his influential work on medical authority in society, Starr (1982), following Arendt (1961) and Lukes (1978), describes two roots of authority: legitimacy and dependence. Authority compels voluntary trust or obedience because we accept that we *should* trust or obey. This is legitimacy. But authority also “holds in reserve powers to enforce” obedience (p. 9) – i.e., the use of force, as in the case of the state, or the use of reason, as in the case of the professions – which compels obedience even when legitimacy is doubted. Moreover, as Starr (1982:11) writes, “as gatekeepers into and out of various institutions, professionals acquire means of ensuring compliance quite independent of any belief in the moral basis of their authority.” This is dependence. As Starr points out, “authority relations are not fixed and untroubled. Often, they go through periods of distress, as when children fight with their parents, students disagree with their teachers, or workers protest against their employers’ policies. In such periods, the legitimacy of authority may be in doubt, but the ongoing dependence of subordinates maintains authority” (p. 10). In the case of the medical profession, we follow doctors’ orders or accept their assessment of our health conditions because we believe in the primacy of the professions’ expertise on such matters; but even if we question this, we nonetheless rely on them for access to medical care.

The history of the medical profession and the trajectory of its authority in society can be understood in light of both the legitimacy of the profession and our dependency on it. In the early days of doctoring, termed the “traditional” era of medicine (1750–1850) by Shorter (1985), physicians enjoyed neither legitimacy nor dependency. Shorter characterizes physicians in the US at this time as “ruinously incompetent” and “aggressively meddlesome” (p. 26). They enjoyed relatively strong relationships with their patients, based largely on the therapeutic value of long and thorough history-taking – largely because they could do little *other* than listening to patients’ stories – but

medical knowledge had not yet developed methods to diagnose conditions, and treatment was rarely successful, if not downright harmful. There was little, if any, respect for the medical profession, and its practitioners had no control over the proliferation of alternative forms of medicine (Starr 1982). Moreover, when people noticed some new physical symptom(s), they were more likely to treat their condition themselves or seek help from alternative healers, and when they visited doctors, it was to get a prescription for stronger medications they couldn't procure on their own. People were thus making medical decisions for themselves, neither defaulting to nor depending on the medical profession for their healthcare.

In the mid-nineteenth century there was a rise in diagnostic technologies and examination techniques like auscultation and palpation, and a general shift to a focus on pathological anatomy and a view of the body as an analyzable and diagnosable object (Foucault 1976 [1963]). Physical examinations and diagnoses were a major distinguishing feature of medical practice in this era, and eventually medical science progressed to improve the quality of medical treatments as well (Shorter 1985; Starr 1982). Larger swathes of the population became "patients," i.e., those who dealt with physical symptoms by visiting their physician (Shorter 1985). Into the early and mid-twentieth century, the medical profession began to consolidate its power, tightening its control over who could gain entry to the profession, locking out or otherwise delegitimizing alternative practitioners, and largely regulating itself (Freidson 1970a,b; Starr 1982; Abbott 1988; Light 2010). During this time, which McKinley and Marceau (2002) have termed "the golden age of doctoring," physicians were seen as the only ones who could legitimately treat the sick, and the perceived gap between medical expertise and laymen's ability to interpret and treat their own health conditions widened (Parsons 1951; Light 1979). A paternalistic relationship between physicians and patients emerged, where patients were normatively expected to take physicians' medical advice "on authority" (Parsons 1951) and "surrender their private judgment" about their medical problems (Starr 1982). In this era

of doctoring physicians enjoyed the height of authority in terms of both legitimacy and dependency.

Beginning in the mid- to late-twentieth century, however, countervailing forces such as government regulation and the intrusion of pharmaceutical and health insurance companies into the business of healthcare began to place external constraints on medical practice, and to interrupt the total discretion physicians had over how to conduct their business (Light 2010). The profession moved toward evidence-based medicine and away from a focus on the patient perspective (Shorter 1982; Mishler et al. 1989; Bensing 2000; Timmermans & Oh 2010). This intensified the paternalistic nature of the physician-patient relationship, but also caused the relationship itself to begin to deteriorate. Patient trust in physicians' competence and commitment to what was in patients' best interests began to further erode as a result of increasing medical malpractice lawsuits, incentivized pay, and a general corporatization of medical practice (Light & Levine 1988; McKinlay & Marceau 2002; Baker 2007; Timmermans & Oh 2010). The legitimacy of the profession began to erode.

At the same time patients were becoming more empowered through health social movements focused on equitable access to healthcare and health literacy, disability and contested illness (Brown et al. 2004) and the increased availability of medical information and communities surrounding specific conditions online (Barker 2008). Patients began to take a more consumerist approach to medical care, deciding on their own who to select as their physician (or when to switch physicians or get a second opinion) and whether or to what extent to follow physicians' advice (Timmermans & Oh 2010). Patients also became more engaged in their own healthcare – practicing self-care, seeking out alternative sources of health information or healthcare, and more actively advocating for themselves in interactions with healthcare providers (Timmermans & Oh 2010; Timmermans 2020). The physician-patient relationship has begun to shift from one between an authoritarian expert and a layman dependent on that expertise, toward something more akin to an encounter between a service provider and a client (Reeder 1972; Stivers & Timmermans 2020).

Patients are becoming less completely dependent on the medical profession for their information, decision-making, and healthcare.

Alongside this evolution in patient engagement has been a corresponding increased emphasis on shared decision-making and patient-centered care models for communicating with patients. With shared decision-making the focus is on informed consent and collaborative decision-making about treatments and the trajectory of a patient's care, where physicians are expected to provide patients with all relevant information, patients are encouraged to participate and voice their own concerns and preferences, and a decision is reached together (Frosch & Kaplan 1999). Patient-centered care incorporates shared decision-making but goes beyond this to additionally encourage discovery and incorporation of the patient's perspective into the diagnostic process, as well as explaining that process to patients (Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Henry 2006; Illingworth 2010; Silverman, Kurtz & Draper 2013), although this may remain more of an aspiration than a clinical reality (Timmermans 2020).

Both of these models undermine the traditional, paternalistic authority of the medical profession, for, as Starr (1982:9) puts it, although authority compels obedience by signifying "a potential to use force or persuasion... paradoxically authority ends when either of these is openly employed." Incorporating patients into the decision-making process and explaining diagnostic reasoning necessarily "presupposes equality and works through a process of argumentation. Where arguments are used, authority is left in abeyance" (Arendt 1961, quoted in Starr 1982). Indeed, this is what scholars of the medical profession and doctor-patient communication are finding, particularly with regard to treatment recommendations. In the context of treatment, patients indeed have some power to negotiate and influence the outcome of their visits (Stivers 2005; Stivers & Timmermans 2020). This is in part because physicians orient to the necessity of patient acceptance by in some cases designing treatment recommendations as options (Toerien et al. 2011; Stivers et al. 2017); by

waiting for or pursuing patient acceptance before moving on to the next activity or closing the visit (Stivers 2005, 2006, 2007; Koenig 2011); and by engaging in persuasion and negotiation when patients overtly resist (Stivers & Timmermans 2020). When it comes to treatment, both physicians and patients display an orientation toward physicians' authority as non-absolute, and toward decisions as shared.

But what of diagnostic assessment? The medical profession enjoys a unique kind of authority when it comes to diagnostic reasoning. As Starr (1982:13) writes, physicians not only provide advice to patients, but before doing so they “evaluate the nature of reality and experience, including the ‘needs’ of those who consult them... their authority extends to the meaning of things.” Generally speaking, the medical profession maintains epistemic primacy in society over defining diagnostic boundaries and what “counts” as a medical diagnosis (Blaxter 1978; Brown 1990, 1995). The profession's autonomy over diagnosis has been curtailed somewhat as evidence-based medicine and protocols developed by external groups like the government and insurance companies standardize the diagnostic process (Heritage, Boyd & Kleinman 2001; Timmermans & Kolker 2004; Timmermans 2010). However, in the literature on medical authority in clinical encounters with patients, it is generally accepted that although physicians' authority over treatment is “under siege” (Stivers & Timmermans 2020), the medical profession has retained its primacy over diagnostic inquiry. This is in part because medical knowledge and technologies have continued to expand, allowing the knowledge gap between clinicians and patients that Parsons (1951) theorized to persist (Stivers & Timmermans 2020), and the legitimacy of the profession's authority over diagnosis to remain largely intact.

Patients also remain entirely dependent on physicians for diagnosis, which is highlighted in extreme cases by situations where patients find themselves on a “diagnostic odyssey” (Timmermans & Buchbinder 2010; Stivers & Timmermans 2017; Lappé et al. 2018). Whereas with treatment

patients are ultimately the ones with the power to follow through with a treatment recommendation, the opposite is true for diagnosis. Physicians are the ones with the power to “give” a diagnosis, to officially log it in a patient’s medical record, and to trigger the social sequelae that follow from a diagnosis, whether negative, as with social stigma or changes in insurance rates, or positive, as when a diagnosis opens the door to resources that would not otherwise be available (Blaxter 1978; Jutel 2014, 2016; Lappé et al. 2018). This gets at an important distinction between the sole authority physicians have over diagnosis versus the shared authority they have over other aspects of medical care they once controlled. In the case of how they do business, e.g., pricing, pay, regulations, and even their day-to-day schedule, physicians now share authority with third parties like the government, insurance companies, healthcare organizations, etc. (Light 2010). In terms of their relationships with patients, authority over treatment – their deontic authority over determining the patient’s future actions – is distributed between both parties (Stevanovic & Peräkylä 2012; Lindström & Weatherall 2015). In contrast, as Heritage (2005:85) writes, “there is broad agreement among medical sociologists and practitioners that diagnostic reasoning in medical settings is an activity based on special knowledge possessed and controlled by the profession of medicine,” and physicians’ authority to diagnose represents “a fulcrum in the exercise of medical authority.”

1.2.2 Medical Authority in Interaction

A key site for the expression of physicians’ authority to diagnose is in visits with patients. From the patient’s perspective, visits with the doctor are indeed the only place where they can influence a diagnostic outcome, and where their own diagnostic reasoning may come up against the physician’s. Patients often do have ideas about the nature and cause of their symptoms before visiting physicians, and for countless reasons – past illness experiences, their own medical knowledge, interactions with the healthcare system, the opinions of those around them, research

they've done on the internet, theories of disease, their emotions surrounding the symptom, and so on (Benyamini 2018). But accepting and orienting to a physician's ultimate authority, especially the authority to define the "nature of reality" and "the meaning of things" (Starr 1982) means deferring to the physician's reasoning and suppressing one's own.

Even if the gap between the physician's and patient's knowledge or reasoning is not as wide as previously supposed, and even in a context of increasing patient engagement and patient-centered care, both physicians and patients continue to orient to a *normative* gap (Peräkylä 1998; McArthur 2018). This is observable in the ways patients work to conceal or mitigate the threat their own diagnostic reasoning presents to physicians' authority. When patients for example use medical jargon (Meehan 1981), make diagnostic suggestions (Gill 1998; Stivers 2002a; Heritage & Robinson 2006a), or volunteer unasked-for information (Stivers & Heritage 2001; McArthur 2018), they do so in ways that actively defer to the physician's clinical expertise, orienting to and enacting an asymmetrical relationship (see also ten Have 1991; Heritage 2005a; Pilnick & Dingwall 2011). And despite physicians' documented tendencies to account for their diagnoses – particularly in no-problem, no-treatment situations (Heritage & Stivers 1999; Peräkylä 1998) – they generally maintain a primarily biomedical approach during information-gathering/ diagnostic inquiry; de-emphasize diagnosis during counseling; and do little to pursue patient response to diagnosis in general, let alone check patient understanding or alignment with the patient's perspective (Mishler 1984; Heath 1992; Peräkylä 1998, 2002, 2006; Robinson 2003; Stivers 2007; Koenig 2011; Heritage & McArthur 2019). Both patients and physicians thus display an orientation toward diagnosis as residing solely in the clinical domain, and toward physicians as the authorities within that domain. A legacy of medical paternalism continues to shape how clinical interactions unfold, despite a concurrent rise in patient engagement and patient-centered care.

Another way clinical interactions continue to be shaped by a legacy of paternalism is in the

normative activity structure of primary care visits for new or acute health problems, specifically when patients are the ones to present the problem (as opposed to physicians raising a concern not symptomatically experienced by the patient, e.g., high blood pressure), which are the focus of this dissertation. Figure 1 portrays an idealized model widely employed to conceptualize this activity structure, based on empirical observations of such visits (Byrne & Long 1976; Robinson 2003; Heritage & Maynard 2006a,b; Koenig 2011; Heritage & McArthur 2019). Each of these phases builds on the one before it, and the progression through them is set in motion when a patient presents a problem that should relevantly be medically addressed (Robinson 2003).

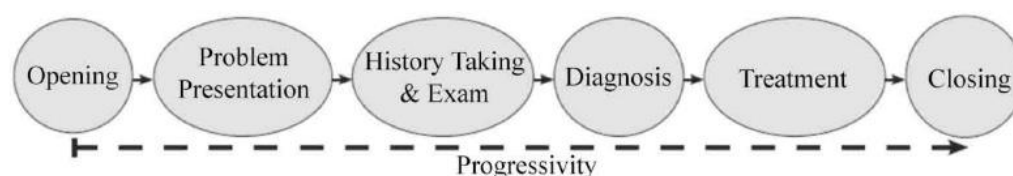


Figure 1: Activity structure of primary care visits for new or acute problems

The activity phases in this model can be grouped into the information-gathering phases, where the physician is gathering information from the patient (problem presentation and history-taking/exam), and the counseling phases, where the physician is giving information to the patient (diagnostic assessment and treatment, including talk about testing, prognosis, etc.). Ostensibly separating these two halves of the visit is some diagnostic assessment of the patient’s problem. Although a physician’s actual mental assessment is not observable, in interactional terms, information-gathering activities are recognizably leading up to a moment of assessment, and counseling activities are recognizably subsequent to and contingent on one.

During information-gathering there is an orientation toward the physician’s assessment as still under development, and patients have – and take – opportunities to shape it. For example, a patient presenting with upper respiratory symptoms may point out the green color of their nasal discharge to direct the physician toward a diagnostic assessment of an infection and therefore

antibiotics (Stivers 2002a, 2007; Gill, Pomerantz & Denvir 2009; Filipetto et al. 2008). Patients have such opportunities during information-gathering because physicians give them the floor to do so through problem solicitations and history-taking questions (Mishler 1984; Robinson 2003).

Once there is a shift to counseling, in contrast, there is an orientation toward the physician's assessment as complete, at least for the purposes of the current visit. Where physicians were previously asking questions, taking information in to be reasoned about, they are now primarily informing the patient, *giving* information based on the assessment that ostensibly resulted from that reasoning. This information-in -> ostensible assessment -> information out structure mirrors other advice-giving contexts (Jefferson & Lee 1981; Heritage & Sefi 1992), and reflects an orientation toward the physician as the authority over diagnostic reasoning. That is, the patient provides the information the physician needs to diagnose the problem, the physician "takes information into the professional knowledge system" to reason about it, and then explains their decisions based on that reasoning to the patient (Abbott 1988:40, quoted in Peräkylä 1998). The normative phase structure of these visits is a one-way flow of information, and the patient does not have a normative space to participate in diagnostic reasoning.

This normative ordering of activities, and the action particulars of each activity (e.g., questioning vs. informing), is shaped by and a reflection of the medical profession's traditional epistemic authority over diagnostic assessment. As Heritage (2005:85) puts it, the moment the physician shifts from information-gathering to counseling is the point "where physicians most completely deploy their cultural authority to define the nature of the patient's problem." The practice and nature of counseling itself is the expression of physicians' authority to reason diagnostically and to define the nature of the patient's problem. Patients' behavior also reflects this authority, as they rarely respond to diagnoses, let alone resist them, in the moment of assessment (Heath 1992; Peräkylä 2002, 2006; Stivers 2007; Koenig 2011; Heritage & McArthur 2019). The

movement of the visit from information-gathering into counseling and then closing is thus a reflection of, and vehicle for, patients' surrendering of their private judgment when seeking medical intervention for their health problems, and for the expression of a doctor-knows-best medical authority over diagnostic reasoning and assessment of those problems.

1.2.3 Diagnosis in Primary Care

In the sociology of diagnosis, diagnosis is conceptualized in two ways: as a set of illness categories designated by the medical profession, and as the process of applying those categories to patients (Blaxter 1978; Jutel 2009). Within the fields of medical care and healthcare delivery, diagnosis tends to be treated as a concrete thing-in-the-world, a "true" underlying pathology causing patients' symptoms, which is pivotal to the practice of medicine (Blaxter 1978; Atkinson 1984; Brown 1995). A central theme in work on the sociology of diagnosis, however, illustrates the undeniable situatedness of diagnosis in a given moment of time or cultural context (Brown 1995). The different names given to health problems, the boundaries of categories of disease, and even what is considered a "disease" change over time (Blaxter 1978; Brown 1990, 1995; Armstrong 2011). Examples that bring the social construction of diagnosis to the fore are those that have changed or been contested over time. Behaviors that exist at the boundaries of what is considered acceptable at various times arise and disappear as diagnoses of disease, e.g., homosexuality (Kirk & Kutchins 1992), alcoholism (Blaxter 1978) and ADHD (Conrad & Potter 2000). Conversely, there are contested conditions which the medical profession has resisted classifying as a biomedical condition, such as fibromyalgia (Jutel 2009; see also Brown, Morello-Frosch & Zavestoski 2011).

Beyond these boundary cases of diagnoses that blur the lines between social behavior, mental health and physical pathology, the construction of medical knowledge more generally shifts over time as technology evolves, systems of categorization are replaced, and even our orientation toward

certain sensations as medically relevant symptoms changes (King 1982; Shorter 1985; Jutel 2009). At one time there weren't even diagnoses *per se* – only labels for symptoms like “fever” – and the range of phenomena considered to be symptoms in the first place was narrow (Shorter 1985). This was partially because the view of disease as located in organs and tissues didn't yet exist (Iida & Nishigori 2016), and relatedly because the body was not seen as an analyzable object, and no diagnostic technologies yet existed for looking inside the human body (Foucault 1976 [1963]).

With a shift to a focus on pathological anatomy, medicine quickly improved its ability to diagnose disease, in the sense of explaining to varying degrees the location and cause of a patient's illness (Starr 1982; Shorter 1985). With this came a shift away from a symptoms-based classification system for illness to a pathology-based one (Armstrong 2011). This coincided with the rise in medical authority in society described above, and a more explicit focus on biomedical explanations for illness and behavior. Medical science and diagnostic testing were – and still are – aimed at reducing or even eradicating diagnostic uncertainty (Kassirer 1989), and medical practitioners are trained from the perspective that medical facts are knowable, diagnoses are discoverable, and medical problems are solvable. In other words, they are trained to think of clinical objects like diagnoses as real, and diagnostic certainty as achievable (Atkinson 1984). This orientation obscures the central role uncertainty and social context play in the actual practice of medicine.

A key area where social context shapes the process of diagnosis is the specialty within which a diagnosis is being delivered. Much of the literature on diagnosis focuses on situations where a diagnosis may play a pivotal role in a patient's life (Jutel 2014, 2016), as in work on unexplained symptoms (Nettleton 2006) and diagnostic odysseys (Timmermans & Buchbinder 2010; Stivers & Timmermans 2017), the role diagnosis plays in providing access to otherwise unavailable resources (Lappé et al. 2018), and methods for delivering the news of a serious or life-changing diagnosis (Maynard 2003). Less work has explicitly focused on diagnosis in primary care settings, where

problems tend to be more run-of-the-mill and self-limiting, and specific diagnosis may be seen as less important than symptomatic treatment (Green & Holden 2003; Heneghan et al. 2009; Silverston 2016). The work that *has* focused on primary care, which has begun to emerge more recently, has suggested that diagnosis may indeed play a different role – and perhaps even be a different *kind* of thing – than in other specialty settings.

This is because primary care is itself a different kind of medical practice. To begin with, the patient population is different. In secondary or specialty care settings the patient population has already been selected via referral. A cardiologist, for example, only has to consider a narrow range of possible diagnoses and is presented with a patient population consisting of people another clinician has already determined needs a cardiologist’s perspective and are thus suffering from a distinct set of symptoms. A primary care physician, on the other hand, sees patients drawn from the general population, who present with a wide range of often overlapping and undifferentiated symptoms (Summerton 2000). The primary care physician’s job is also different from the cardiologist’s. Whereas a cardiologist must establish a precise classification of a patient’s condition and initiate appropriate treatment, a primary care physician’s main concern is to identify patients whose symptoms may indicate serious illness for diagnostic testing or referral (Heneghan et al. 2009). For those whose symptoms are not serious, which represents the bulk of patients, a primary care physician’s job may merely be reassurance that there is nothing seriously wrong, initiation of symptomatic treatment, and watchful waiting (Scott 1977; Green & Holden 2003).

When non-serious illness defies precise classification, physicians may use bucket diagnoses of “non-disease” (Scott 1977), or what Dixon (1986) calls “diagnostic black boxes,” which satisfy the physician’s and patient’s desire to name the patient’s problem – a desire that some see as “getting in the way” of the real job of a primary care physician (Howie 1972) – without needing to establish a precise diagnosis. Examples of these include “viral infection,” which typically means “not a bacterial

infection” and “sprain,” which typically means “not a fracture” (Dixon 1986). Indeed for most patients who do not need further testing or referral, symptomatic treatment is often possible without a diagnosis – either because diagnosis isn’t possible, or because treatment and/or recovery is possible independent of a specific diagnosis (Green & Holden 2003). Even if the physician could in theory investigate a problem further for a more precise diagnosis, it may not be clinically necessary or relevant.

These differences between primary care and other subdisciplines of medicine are reflected in their respective diagnostic classification systems. The first attempt at formalizing the classification system for diagnosis was the International Classification of Disease (ICD) in the late eighteenth century (Armstrong 2011). This was revised over the decades as medical knowledge and diagnostic technologies evolved, and it proved helpful in the practice of medicine in contexts like hospitals and secondary care. There were problems when it was used in primary care, though, as physicians struggled to apply the classification of distinct diseases to the “rawness of undifferentiated human illness and distress” they were seeing in their practice, especially in cases where the patient’s condition did not require a firm or specific diagnosis (Armstrong 2011:801; see also Heneghan et al. 2009). The initial response to this difficulty was a general suspicion that primary care physicians simply were not very good at diagnosis, or were dealing with too many problems that didn’t belong in the clinical office to begin with.

Eventually it was acknowledged that primary care may simply be a different *kind* of medical practice, and that what primary care physicians do in practice vis-à-vis diagnosis does not line up with the organizing principles of the ICD. In response, in the 1970s the College of General Practitioners worked to create a separate classification system specifically for general practice, which is currently called the International Classification of Primary Care (ICPC). This new system added to the ICD some less precise diagnostic categories, symptomatic diagnoses, and an “other” category

that allowed physicians to identify a problem as an “other known disease not otherwise specified” (Research Committee of the College of General Practitioners, cited in Armstrong 2011). The difference between how the medical field categorizes disease and how primary care works in practice has raised the issue that diagnosis is not some objective “thing-in-the-world” to a level of awareness *within* the field of medicine, leading to the ICPC. As Armstrong (2011:801) puts it, primary care represents a “frontier zone where a dominant classification system struggles to maintain order,” which reveals the ways diagnostic classification more generally attempts “to promote and maintain a certain medical reality.”

What does all of this mean for the *process* of diagnosis in primary care in clinical visits with patients? Heritage and McArthur (2019) argue that there is an observable “devalorization” of diagnosis in primary care visits for new or acute problems. Physicians indeed only deliver “official” diagnoses – utterances that name, describe, or explain a patient’s problem, delivered at the close of information-gathering – approximately half the time, and often do not leave space for patient response before proceeding to other matters. Patients align with this orientation in that they rarely respond to diagnoses more than minimally (e.g., *mm hm*), if at all (see also Heath 1992; Peräkylä 2002, 2006). When physicians do name a diagnosis, it is often indeterminate, marked as uncertain, minimized, or some combination of the three (Heath 1992; Peräkylä 1998; McArthur 2018; Heritage & McArthur 2019). By delivering such fuzzy or uncertain diagnoses and then moving straight to treatment and/or closing, physicians are orienting to them as “good enough” for the situation. Heritage & McArthur (2019) also found that, when physicians do not deliver official diagnoses, they often instead move straight to treatment, or reassure the patient that the problem is not something serious and *then* move to treatment, orienting to diagnosis as irrelevant. In other cases physicians discuss diagnostic uncertainty or recommend tests before moving to treatment recommendations and visit closings, often with no plans for a follow-up visit, which again orients to naming a precise

diagnosis as irrelevant. These findings align with the notion that, in general, primary care physicians do not see their main job as establishing a precise diagnosis, but rather identifying concerning cases for referral, and otherwise ruling out serious illness and initiating symptomatic treatment.

It is important to note, however, that focusing on what primary care physicians are *not* doing in terms of diagnosis assumes the perspective of an ICD-style approach to categorizing disease, and toward precise diagnosis *per se* as the fundamental way the medical profession at large wields their authority to evaluate the nature of the patient's problem before initiating clinical action. This neglects what primary care physicians *are* doing in terms of assessing the patient's problem as they move from information-gathering to counseling. The ICPC has attempted to capture this. When it was first created it was called the International Classification of *Health Problems* in Primary Care, which explicitly focused on the concept of a "health problem" as a replacement for the IDC's focus on pathologically caused diseases (Armstrong 2011). Health problems in the ICPC are, as mentioned above, often vaguer than the IDC's diagnoses. Moreover, the ICPC takes a three-pronged approach to defining health problems, such that a problem can be coded based on (1) the patient's reasons for the encounter, (2) assessment of the problem from the physician's point of view, and (3) process of care (decisions, plans etc.) (Armstrong 2011). This approach aligns more with the reality of primary care, where the result of a visit may not always be a diagnosis *per se*.

One particularly noteworthy shift in language in the ICPC is from "diagnosis" to "assessment," which broadly represents the physician's interpretation of the patient's health problem and may, but does not necessarily, include a precise diagnosis (Armstrong 2011). This lexical choice is an apt one for the context of primary care and may be useful for analyses of what physicians are doing in visits with patients in terms of defining or assessing the situation, beyond delivering official, IDC-style diagnoses. In this dissertation I use the terms "assessment" and "diagnostic assessment," focusing on these more broadly as potential objects of resistance rather than diagnoses *per se*.

A physician's assessment of a patient's problem *may* include a formal diagnosis denoting the pathological cause of the patient's symptom; and that diagnosis *may* be communicated in the visit (e.g., "you have an Achilles tendon tear"), perhaps even in the "official" slot for diagnosis delivery following information-gathering and preceding talk about treatment. But the notion of assessment is much broader than diagnosis *per se*, including for example what is *not* causing the problem (rule-outs of serious illness), whether the problem is concerning or self-limiting, whether further diagnostic inquiry is merited, and so on. It may also include, as the ICPC acknowledges, an understanding of why the patient is there. For instance, is the patient presenting with foot pain because her mobility is limited and she wants a handicap placard, or because she's worried that it's indicative of diabetes complications? Understanding the patient's reason for the visit may shape the physician's plans for what further information to pursue and how to address the problem.

Although physicians may not always name a specific or certain diagnosis, they do convey aspects of their assessment to patients throughout counseling. For instance, ruling out a serious health condition like cancer but not providing an alternate diagnosis conveys an assessment of what is *not* causing the patient's symptoms, as well as assessments that the patient's symptoms do not otherwise merit further diagnostic investigation and that the most appropriate course of action is reassurance. Similarly, if a physician does not explicitly mention cancer, let alone rule it out, a patient may infer an assessment either that cancer is not a relevant diagnosis to pursue and rule out, or that the physician *has* ruled it out but did not consider communicating such a rule-out necessary for addressing the patient's concerns. In another example, if a physician spends time explaining how a diagnosis or treatment deals with a specific symptom, a patient may infer an assessment that *that* symptom is the most worrisome, either from a clinical perspective or from the physician's understanding of the patient's illness experience. The possibilities of what a patient may infer about a physician's assessment of their problem during counseling are innumerable, but the point here is

that it may be implied in what the physician does or doesn't do during counseling, or how they describe the patient's condition.

In a cognitive sense, clinical assessment is an “invisible process” (Bickley 2007), where “from the moment you see the patient and listen to the chief complaint, you develop ideas about what may explain the complaints and how you can determine their probable nature and cause with increasing certainty” (Mollica 2001). This process is not constrained to any given activity phase in a clinical visit; in some cases, physicians may have made up their minds long before concluding the information-gathering activities of the visit. The process of clinical assessment is not even constrained to a single visit, as a physician's process of assessment may begin before seeing the patient – with a chart review, discussion with a nurse, or knowledge of the patient from prior visits – and extend beyond the end of the visit, as more data are gathered through diagnostic testing, discussions with specialists, tests of treatment or time (Heneghan et al. 2009), or follow-up contact with the patient. Clinical assessment is an ongoing process, and there is no single cognitive “moment” of assessment.

But assessment is also a public moment during clinical encounters with patients. The normative phase structure of primary care visits for new or acute problems, discussed earlier in this chapter, is structured around this moment, such that information-gathering activities are observably leading up to it and counseling – or information-*giving* – activities are observably based on it. The shift into counseling is recognizably the culmination and outcome of the prior investigative activities (Heritage & McArthur 2019), and physicians often orient to it as such with turn-initial items such as “well” and “so.” This separation of cognitive and other internal processes and the public displays of them has been well documented in the conversation analytic literature. An early and particularly relevant example is Heritage's (1984, 2002) work on “oh,” which shows that although this particle is meant to display a mental “change of state,” its production is not merely tied to an actual “moment”

of, e.g., remembering, realizing, etc., but is rather shaped by the local interactional context within which it's produced. For the purposes of understanding how diagnostic assessment – and resistance to it – unfolds in clinical interactions, the focus of this study will be on assessment as a public moment rather than a cognitive one.

1.2.4 *When the Train “Leaves the Station”*

We may now return to the difficulty of the moment described at the outset of this chapter and consider *why* it's so difficult. In primary care visits for new or acute health problems, physicians may not always *diagnose* patients, but they do always *assess* the nature of the patient's problem in some way. This assessment is a cognitive process, but also a public moment around which the visit is oriented, such that information-gathering activities lead up to it, and counseling activities are subsequent to and based upon it. It is in this moment that the physician wields their authority to “evaluate the nature of reality” and “the meaning of things” in terms of clinically assessing the patient's problem, as Starr (1982) puts it. If a patient interrupts counseling to raise residual concerns about their problem or its assessment, to what extent is this a problematic situation and why?

One could offer a top-down account of authority, explaining this as a situation where diagnosis resistance is a problem because physicians merely *have* the authority to assess the patient's condition, and patients do not have the knowledge or rights to challenge that authority. But this account treats medical authority as something existing independently “out there” in the world, shaping what patients are allowed to do in visits with physicians through some set of implicit, externally imposed rules. What such an account would miss is how physicians' medical authority is lodged within – reflexively shaping and shaped by – the clinical interactions where it is expressed.

Talk in institutions is distinct from the unconstrained back-and-forth of everyday conversation. This is not to say the rules of interaction in institutional contexts are *completely* different

from everyday talk. Rather, talk in institutions is a constrained form of talk in everyday contexts (Heritage & Clayman 2010). These constraints shape talk at all levels, from the overarching activity structure of an institutional encounter to the shape of sequences of talk, to the design of individual turns themselves. Talk is typically further constrained by social role, such that participants have asymmetrical rights and obligations to engage in different kinds of talk. These constraints both reflect and enact the norms of the institution itself (Heritage & Clayman 2010), as well as the social roles of those participating in the encounter. They are not hard-and-fast rules that participants are bound to follow, but rather norms that are enacted and oriented to by participants as part of carrying out their joint institutional project(s). This is the reflexive nature of talk in interaction – social norms shape interaction, but conversely the ways participants in interaction carry out their conversations shape social norms, “talking the institution into being” (Heritage 1984a). The macro and the micro of our social lives are fundamentally intertwined.

In the case of primary care clinical encounters, the macro is medical authority in society, and the micro consists of the particulars of the interaction. To say that diagnosis resistance is a problem solely because of medical authority misses this mechanism. The shape of the clinical encounter in terms of activity phases is entirely oriented toward the purpose of the visit – for the patient to get help with a health problem they can’t solve on their own – and thus toward the physician’s primary responsibility and authority over assessing and then addressing the patient’s problem. The information-in -> information-out model of the visit both reflects and enacts this. When the “train has left the station” because the physician has shifted from information-gathering to counseling, resisting the ostensible diagnostic assessment preceding that shift is not directly – or not merely – an issue of challenging medical authority, but of stopping the interactional train. Diagnosis resistance is an interactional problem because of medical authority and a legacy of medical paternalism; and it’s conversely an authority problem because of how the interaction is shaped by and oriented to a

legacy of medical paternalism.

In the broad scheme of, say, “medical authority in society,” moments of diagnosis resistance of the sort that will be analyzed in this dissertation may seem trivial. They are not, of course, trivial for the patients who find themselves in a situation where they have residual concerns about their health problem but no legitimate way to raise them. Neither are they trivial in society. The reflexive nature of talk and social structures means that this moment, and the particulars of how both patients and physicians communicate around it, are not only shaped by norms of medical authority, but conversely shape them. In the three main analytical chapters of this dissertation, I consider how medical authority shapes and is reflected in the interactional particulars of this moment, and in the concluding chapter I discuss the other side of this reflexive relationship, considering what the interactional particulars of resistance can tell us about the status of medical authority in society.

1.2.5 Diagnosis Resistance in the Literature

Moments where patients resist a physician’s diagnostic assessment in primary care are not directly addressed in the broader applied literature on communication in healthcare. For the most part the issue of patient disagreement with physicians’ assessments has not yet been identified *as* a distinct problem in doctor-patient communication. Some topics of study are related to or get at some partial aspect of this, but without drawing out the overarching issue of diagnosis resistance. These include studies focusing on unmet patient expectations, requests for diagnostic testing (and its correlate over-testing), and what has been termed in the literature “hidden agendas” or “doorknob” concerns, i.e., concerns patients wait to raise until later or at the end of a visit.

In his review of the literature on patient expectations, Kravitz (1996) notes a few important dimensions of the term. Expectations may be probability-based, as in a patient’s expectation of the likelihood that something will happen during their visit, or they may be value-based, as in a patient’s

hope or desire for a certain clinical event. Most expectations have to do with the “process” aspect of medical care, as in what the provider actually does during a visit – information-gathering, testing, prescription, etc. – but may also include expectations about the institution and staff, as well as longer-term outcomes like “I will get better.” Even process-oriented expectations, though they may be well-formed as in “I want an antibiotic,” may be more amorphous as in “I hope the doctor shows interest in my problem and tries hard to solve it” (p. 12). In general, reviews of the literature on patient expectations agree that there is not enough consensus on what is meant by the term or how to measure it (e.g., Kravitz 1996; Thorsen et al. 2001). This may indeed be because patient expectations are so multifaceted and sometimes amorphous for patients themselves.

Many studies on patient expectations in the health communication literature tend to shy away from the more amorphous types of expectations, focusing instead on the specific outcomes patients might hope for, e.g., diagnosis, prognosis, prescriptions, tests and referrals (e.g., Jackson & Kroenke 2001). These studies tend to ask patients before a visit what they hope to get out of their visit, and then determine whether those expectations were met by, for example, asking patients or physicians at the end of the visit whether *they* thought these expectations were met. Some studies have found, however, that participants’ perceptions are not always in alignment with one another; for example, physicians and patients don’t always actually agree on whether patient expectations were met, even when those expectations are spelled out explicitly (Hooper et al. 2005). To get around this issue, other studies rely on coding schemes which researchers apply to recordings of visits to identify whether some expectation is met or not. In general, studies on this topic focus on how frequently various types of expectations are met or unmet, or how unmet expectations affect post-visit outcomes like patient and physician satisfaction with the visit (e.g., Jackson & Kroenke 2001; Hooper et al. 2005). Absent from these studies is a consideration of what problems, if any, unmet patient expectations present *in the visit* as it unfolds.

Somewhat related to these studies on patient expectations is an area of study focusing on diagnostic testing. Patients may desire diagnostic investigation for a variety of reasons, including suspicion of a particular diagnosis, fear of serious disease, or the need for explanation or validation of distressing symptoms (Kravitz & Callahan 2000; Espeland & Baerheim 2003). Most studies investigating over-testing are survey-based; some have found that perceived patient expectations and anticipated conflict with patients may be one driver of over-testing (Espeland & Baerheim 2003; Whiting et al. 2017). Research directly linking communication behaviors to testing outcomes is still in its infancy. Early studies have suggested that physicians who use more patient-centered or less “technical” communication styles order fewer unnecessary tests and spend less on diagnostic testing overall (Bertakis et al. 1999; Epstein et al. 2005a; May et al. 2016). Most studies in this area focus on patients’ direct requests for tests, and many use standardized patients following scripts to enact such requests, despite other studies showing that patients rarely express desires so directly (e.g., White, Levinson & Roter 1994; Gill, Halkowski & Roberts 2001; Stivers 2002a,b; Keitz et al. 2007). Many of these studies also use pre-determined coding schemes neither generated nor validated through analysis of the data, which tends to erase the context and meaning of coded conduct and makes it difficult to identify how specific behaviors emerge and are dealt with in visits. Thus, although these studies begin to get at one reason patients may resist a physician’s diagnostic assessment, they do not actually get at how patients’ expectations for diagnostic tests, and physicians’ responses to those expectations, emerge or potentially lead to resistance in clinical encounters.

One area of research that does begin to get at what patients do when their concerns or expectations have not been met consists of studies focusing on what has variously been described as “by the way syndromes” (Byrne & Long 1976; White, Levinson & Roter 1994), “hidden agendas” (Barsky 1981; Silverman 2005) and the “doorknob phenomenon” (Finset 2016), which all refer to cases where patients raise new or additional concerns in the closing moments of a visit. These

studies generally describe late-arising concerns as more psychosocial or emotionally charged than the primary concerns patients present at the beginnings of the visits and suggest that patients may wait until the end of a visit to bring up such concerns because they're embarrassed to do so, or they want to "test the waters" with the physician's response (Barsky 1981; White, Levinson & Roter 1994). Robinson (2001) highlights an additional interactional reason patients may wait until closing to bring these up, arguing that there is no place during counseling for a new topic to come up "naturally," so patients wait until the transition to closing to take the floor and introduce a new topic. In any case, late-arising concerns can be challenging for physicians as they may result in an entirely new diagnostic investigation, or even revision of what has already been discussed (Barsky 1981; White, Levinson & Roter 1994; Silverman 2005), in a context where physicians are already limited on time. Advice for physicians typically involves early agenda-setting and signposting, solicitations of additional concerns, and giving patients space to expand on their concerns early on (Silverman 2005; Roter & Hall 2006; Silverman, Kurt & Draper 2013), although in practice this rarely happens (Robinson, Tate & Heritage 2016).

These studies generally orient to patients' late-arising concerns as separate from and additional to the patient's primary health concern. However, some concerns are related to or even part of a patient's main concern (Robinson 2001b), such as a desire for diagnostic or etiological explanation of symptoms, or reassurance that symptoms are not indicative of serious illness (Barsky 1981; White, Levinson & Roter 1994). By focusing on late-arising concerns as solely separate concerns which the patient is withholding until the end of the visit unless otherwise prompted, these studies neglect their potentially locally emergent nature. That is, if a patient doesn't voice concerns about their problem until late in the visit, we cannot know for sure that these were fully-fledged concerns at the beginning of the visit, as opposed to something that emerged more locally, in response to how the physician assessed the problem and counseled the patient about it. Even if we

cannot know for certain whether a patient's late-arising concern existed from the beginning or was locally emergent, it is important to acknowledge that, by the time a late-arising concern is brought up, the physician *has* already assessed the problem. Although these studies on late-arising concerns may indeed be looking at some of the same phenomena that I describe here as diagnosis resistance, they fundamentally neglect the potentially resistant nature of such actions, and how their production may be shaped by an orientation toward the physicians' authority to assess the patient's condition.

In sum, although areas of study within applied healthcare communication research get at some issues that overlap with or potentially inform a study on diagnosis resistance, none of them identify or examine resistance *qua* resistance.

Even a brief Google search, however, quickly reveals that the issue of how to voice disagreement or residual concerns about how a health concern has been assessed is of real concern for patients. Articles abound on news and health information websites discussing what patients can do if they disagree with their physician, and why it might be so difficult to do so. An article in US News & World Report entitled "What to do when you disagree with your doctor" suggests that disagreeing with a treatment recommendation is easier than disagreeing with a diagnosis, which should generally be avoided (Godman 2018). Others give explicit advice for how a patient might push back against a diagnosis, for instance "be firm but polite," "express your concerns honestly and ask your questions about diagnosis," "talk about why you disagree or what your concerns are," "share information or research you've found," and "ask the doctor to explain their reasoning" ("How to disagree" 2018). A public-facing article by the Society to Improve Diagnosis in Medicine (SIDM) suggests asking direct questions like "what (else) might this be?," requesting a referral to a specialist, or more generally "speaking up" (Epstein n.d.). The actions these websites suggest are surprisingly direct in terms of challenging the physician's expertise, and rarely actually appear in recordings of clinical visits.

Articles like this do acknowledge the tightrope patients may be walking when resisting a diagnosis. For instance, the SIDM article suggests that patients should be “willing to fight for yourself and your body,” but at the same time not be “willing to put on the boxing gloves” at the outset of a visit, instead waiting to see how the physician addresses the issue first and only later pursuing further information. An article in the Atlantic entitled “Questioning the doctor, challenging a god” points out that although patients are often encouraged to discuss concerns or questions with their doctor, this is easier said than done because of patients’ fear of losing their physician’s goodwill (being labeled a “difficult patient”), apprehension at challenging the physician’s authority, and self-consciousness at taking up the physician’s limited time (Wagner 2012, discussing Frosch et al. 2012). But despite this evidence that diagnosis resistance may not only be a salient issue for many patients but a difficult one to resolve in interactions with physicians, this has not emerged as a distinct area of study within applied healthcare communication research.

One area of research that is an exception to the general inattention paid diagnosis resistance in applied healthcare communication is conversation analytic studies of diagnosis delivery and response in primary care. Studies in this area vary slightly in what they define as diagnosis resistance, but they generally include any actions which reject a diagnosis, stall progressivity of the diagnosis by introducing new information, or otherwise encourage the physician to reassess the patient’s complaint. Actions that fall into these categories include overtly rejecting a diagnosis (Peräkylä 2002, 2006), calling a physician’s diagnostic inference into question (Stivers 2007), questioning the evidence upon which a diagnosis is based (Peräkylä 2002; Stivers 2007), (re)proposing a candidate or alternate diagnosis (Peräkylä 2002, Stivers 2007, Ijäs-Kallio et al. 2010), invoking information received in a past medical visit or experience with a similar illness in the past (Ijäs-Kallio et al. 2010), and (re)describing symptoms (Heath 1992; Peräkylä 1998, 2002; Ijäs-Kallio et al. 2010).

The focus of these studies is not always on diagnosis resistance *per se*, and their framing does

not treat as central the challenges resistance presents for both physicians and patients. They rather focus on other processes within which diagnosis resistance is implicated, for instance treatment resistance in the context of upper respiratory complaints that are not treated with antibiotics (Stivers 2007); the relationship between diagnosis design and likelihood of patient response (Heath 1992; Peräkylä 2002, 2006); and concordance in medical care (Ijäs-Kallio et al. 2010). Moreover, according to these studies, patients rarely actually resist diagnoses (Heath 1992; Peräkylä 1998, 2002; Stivers 2007; Ijäs-Kallio et al 2010; Heritage & McArthur 2019). These findings may be one factor underlying the perspective, mentioned earlier, that physicians' authority to diagnose in clinical encounters is in general *not* changing. But the finding that diagnosis resistance is so rare may itself be shaped by studies' fairly restrictive definitions of where and how diagnosis resistance may occur.

First, existing conversation analytic studies look for diagnosis resistance in one position: in response to a diagnosis. This makes sense, because the interactional import of an action is the product of both its content and position. For instance, in the context of primary care visits for acute problems, a patient's symptom description may be hearable as merely providing relevant information about a health problem when it's produced early in a visit in response to a solicitation for such information. When produced in immediate response to a diagnostic assessment, however, the same symptom description may be hearable to the physician as resistant to that assessment (Heath 1992; Peräkylä 1998, 2002; Ijäs-Kallio et al. 2010). Yet there are a number of reasons why only looking at patient response to diagnoses does not cast a wide enough net for capturing resistant patient behavior. First, physician behavior suppresses the likelihood of patient response. In a recent study, Heritage and McArthur (2019) found that primary care physicians only name a diagnostic assessment half the time, which means patient resistance would be analytically overlooked in cases with no diagnostic moment. While conducting that study, Heritage and McArthur (2019) also observed that even when they do name a diagnostic assessment, physicians often orient to patient

response as irrelevant by not gazing at the patient during diagnostic assessment delivery, or by obscuring the ‘slot’ in which a patient might respond.

Moreover, even when patients are given a chance to respond, they often withhold it (see also Heath 1992; Peräkylä 1998, 2002). This may display an orientation to the physician’s authority over matters like diagnostic assessment (Heath 1992; Peräkylä 1998, 2002; Stivers 2007; Heritage & McArthur 2019). But conversation analysts have repeatedly shown that patients do not merely withhold challenges to medical authority as a matter of course; rather, they do potentially threatening actions in mitigated ways that maintain an orientation to the physician’s authority, for instance by making diagnostic suggestions while downplaying their knowledge relative to the physician’s (Gill 1998). It follows that diagnosis resistance may be uncommon in direct response to diagnoses because that is where it is most strongly hearable as a challenge to the physician; instead, patients may be resisting physicians’ diagnostic assessments in other interactional positions where that challenge may be more or less mitigated.

1.2.6 The Current Study

In this dissertation, I cast a wider net for diagnosis resistance by looking at any patient action that could potentially be resistant from initiation of counseling – i.e., after the ostensible moment of assessment described above – through visit closing. In Chapter 2 I propose an operationalization of diagnosis resistance that draws on concepts introduced in this chapter, focusing on the intersection of the physicians’ traditional authority to assess a patient’s problem and to progress the visit from assessment through counseling and visit closing. I then build out my analysis of diagnosis resistance by examining how physicians respond to it in Chapter 3, and the contexts leading up to it in Chapter 4. In these chapters I focus on how resistance is shaped by and reflects an orientation to physicians’ medical authority in society. In the conclusion of this dissertation, I reflect on my findings in all

three chapters, revisiting the reflexive interweaving of social norms and talk in interaction to consider how participants' behavior in moments of diagnosis resistance in turn enact and even shape medical authority in society.

This work contributes to the conversation analytic literature by building out an operationalization of diagnosis resistance in primary care that more closely reflects how assessment works in that setting and how patients resist when they have residual concerns. It also contributes to the broader field of applied healthcare communication research by rendering diagnosis resistance identifiable *as* a discrete phenomenon, something to which, as I will discuss in the next section, conversation analysis is well-suited. The work presented in this dissertation additionally contributes to the medical sociological literature on authority by considering the ways physicians' traditional authority to assess the nature of a patient's condition actually is – but also in some ways is not – shifting, particularly in primary care. Finally, this work contributes to work examining how and why patient concerns are not being met in clinical encounters, what's going wrong, and what might be changed in an effort to provide care that more adequately attends to, respects, and treats as central the patient's perspective and lifeworld experience of their illness (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992; Mishler 2005).

1.3 METHODOLOGY & DATA

1.3.1 Conversation Analysis in Medical Contexts

Used by researchers of physician-patient communication for the past four decades (Heritage & Maynard 2006a,b), conversation analysis is unique in its strengths both as a qualitative method and as a basis for quantitative study, and is particularly well-suited as a method for identifying a phenomenon as multifaceted in its accomplishment as diagnosis resistance.

As a qualitative method, conversation analysis provides a theoretical framework and set of

systematic procedures for the grounded exploration of what physicians and patients orient to as meaningful in their conversations with each other, and for identifying specific communication practices they use to achieve their goals. Conversation analysis is well-suited to the present task of operationalizing diagnosis resistance in order to examine its import for communication in the practice of primary care and the status of medical authority within that field of medicine. This is because, as I will show in subsequent chapters, diagnosis resistance is locally emergent, treated as socially problematic, and multifaceted in terms of the actions and practices through which it is accomplished. It is thus not as easy to identify *as* a discrete phenomenon as, for example, single actions like requests for tests or treatment.

What conversation analysis provides is a systematic way of analyzing a given turn at talk – e.g., a question about a symptom – that examines its import for the ongoing interaction in terms of more than what it “is” at face value. That is, a turn’s design, position within a sequence, position within some local activity, hearable connection to a speaker’s interactional project, and situatedness within a specific social or institutional context imbued with a particular set of social norms for meaning-making and understanding, all matter in terms of what a turn can be accountably be heard to be doing, as well as what it may be accomplishing “off record” (Heritage 1984a; Sidnell & Stivers 2014; Sidnell & Enfield 2017). This theoretical framework and methodology for understanding human action in everyday and institutional contexts provides the analytical scaffolding necessary for operationalizing a concept as potentially nebulous as diagnosis resistance.

Once identified and operationalized, conversational practices can be used as the basis for coding categories for quantitative study. This allows distributions of practices to be explored, which is itself of analytic value. Hypotheses about relationships among coded practices can also be tested (Stivers et al. 2003; Heritage & Maynard 2006a,b; Stivers 2015), typically using the chi square test of association or multivariate regression analyses. Studies using conversation analysis in this way have

shown associations among communication practices within visits, for example the effects of diagnosis design on the likelihood of patient response (Peräkylä 2002, 2006) or the effects of question design when soliciting additional concerns on the likelihood of patients actually revealing additional concerns (Heritage et al. 2007). Studies using this method have also shown associations among communication practices and other outcomes like patient satisfaction (Robinson & Heritage 2006), physician prescribing practices (Mangione-Smith et al. 2015), or patient agreement to vaccinate their children (Opel et al. 2015). The present study uses conversation analysis both qualitatively and as a basis for quantitative study to map out an as-yet indistinct landscape of diagnosis resistance (i.e., to examine *what* patients and physicians are doing in these moments) and to examine *how* their behaviors influence one another and the trajectory of the clinical encounter. Examining this landscape in numerical terms contributes an added dimension to considerations of what diagnosis resistance means for medical authority.

1.3.2 Datasets

Two datasets are used in this study. Both consist of video recordings of naturally occurring primary care visits for new or acute health problems, and collection and use of both datasets was approved by the UCLA Institutional Review Board.

1.3.2.1 AMH dataset

The primary dataset consists of 75 visits recorded by the researcher between 2017 and 2018, with 5 primary care physicians in 3 clinics within a single health system in the greater Los Angeles area. This entire dataset was coded according to the communication patterns and practices identified throughout this dissertation, and is the only dataset used in tables illustrating distributions and associations among practices.

One of the clinics in the data was in a hospital setting, and both physicians in the clinic were

researchers who only spent one half day in the clinic per week. The other two clinics were in the community, and the three physicians who participated from these clinics were full-time clinicians. Both community clinics offered both standard primary care and urgent care. One physician in the dataset, a full-time clinician, had been practicing medicine for thirty years and ran the clinic where he practiced; the rest had been practicing for thirteen years or less. Two physicians were female and three were male. Two physicians identified as white, one as Black and Hispanic, one as Hispanic, and one as Middle Eastern/ North African.

Fifteen patients were recruited per physician. Patients were approached consecutively in their private exam room while they waited for the physician to come in. Patients were eligible to participate if they were 18 years or older, able to conduct the health visit in English, and if their reason for visiting the doctor consisted of at least one new and/or acute health problem, i.e., a problem which had not already received a diagnosis, and for which the patient had not already seen this doctor. Participation was voluntary, and there was no financial incentive to participate. If a physician entered the room before recruitment was complete, all recruitment activities were stopped and the visit proceeded as usual, without being recorded.

Patients were oversampled for musculoskeletal problems relative to the proportion of patients whom physicians typically see with these problems, with at least 8 of the 15 patients recorded for each physician presenting with at least one musculoskeletal concern. A large share of the conversation analytic data in primary care has represented routine upper respiratory complaints (e.g., sore throats, congestion, cough). This has led to major findings relevant to that category of complaints, e.g., the ways physicians manage (or give in to) patients' appeals for antibiotics (e.g., Heritage & Stivers 1999; Heritage et. al 2010). However, other common complaints have largely been analytically neglected. Studies have shown that the economic and social costs of musculoskeletal conditions are substantial (Yelin & Callahan 1995), that patient satisfaction related

to musculoskeletal problems in primary care is low (Mermod et. al 2008), and that uncertainty surrounding musculoskeletal problems like low back pain is particularly high (Darlow et. al 2014). This dataset can be used to address the experiences and needs of this relatively under-studied but important subset of primary care.

During recruitment, once a patient signed the consent form, a small camera was set up in a corner of the room, turned on, and the researcher left the room. Videos thus recorded the very beginnings of the visits and captured everything until the patient left and the researcher re-entered the room to turn the camera off. In some cases where diagnostic tests were recommended, those tests were performed on the same day, on-site (e.g., x-rays). The camera did not follow the patients through the process of getting the test but did capture communication with the physician both before and after the test. Physicians and patients were given instructions for how to turn off the camera if they wished, and the researcher stood just outside the room if necessary. No one turned off the camera during any of the recorded visits. Participants were also provided a small piece of cloth to cover the camera so that video could not be captured but audio could. Only one patient used the cloth to cover the camera during a physical exam.

Patients filled out a pre-visit and a post-visit survey. The pre-visit survey included the main reason for the visit, other health concerns, the relative importance to the patient of various types of information they may receive in the visit (e.g., diagnosis, etiology, prognosis; Kindelan & Kent 1987), self-evaluation of health status, attitudes toward patient-centeredness (Krupat et al. 2000), and demographic information (see next section). The post-visit survey included measures of patient satisfaction (Marshall & Hays 1994), trust (Dugan, Trachtenberg & Hall 2005), and feelings of uncertainty (Mishel 1981). After each visit, physicians answered a three-question survey including the most likely diagnosis for the patient's new or acute problem, other diagnoses they considered during the visit, and their perception of what kind of information the patient was most looking for during

the visit (e.g., diagnosis, etiology, prognosis). After each physician's participation in the project was over, they filled out a post-participation survey including demographic information, attitudes toward patient-centeredness (Krupat et al. 2000), and tolerance of uncertainty (Gerrity et al. 1995).

1.3.2.2 PCT dataset

The second dataset consists of 211 visits recorded between 2003 and 2005, with 71 primary care physicians in 33 clinics in Southern California. This dataset has been partially, but not yet entirely, coded according to the communication patterns and practices identified throughout this dissertation. In this study this dataset is used only for illustrative qualitative analyses. Future work exploring extensions of the findings of this dissertation will include coding of this dataset, which may reveal differences in distributions or associations among communication practices over time. However, for the purposes of this dissertation there is no reason to believe, based on qualitative analyses, that the communication practices surrounding diagnosis are substantively different from those in the AMH dataset.

Patients were recruited consecutively from physicians' waiting rooms on scheduled research days. A video camera was typically mounted in a ceiling corner or on a movable pole; in both cases the video could be obscured, for example by an exam curtain or by simply turning the camera to face the wall. Video captured the patient's interaction with the nurse and the physician. In a small number of cases the video captured conversations with the physician both before and after an on-site diagnostic test, although such tests were less common in the years these videos were recorded than in the AMH dataset.

Participating patients filled out pre- and post-visit questionnaires. The pre-visit questionnaire was a modified version of a national survey of patients' expectations for medical visits (McBride et al. 1994) and also included demographic characteristics, length of relationship with the physician,

and expectations of the behavior and actions of the nurse and physician. The post-visit questionnaire was a modified version of the Patient Satisfaction Questionnaire (Marshall & Hays 1994), evaluating general satisfaction and satisfaction with the physician's technical quality, interpersonal style, communication and time spent. Data were collected by John Heritage, chair of the faculty committee, who has granted access for this dissertation.

Table 1 displays some patient characteristics in both datasets.

Table 1
Patient Characteristics

<i>Characteristic</i>	<i>AMH dataset Freq. (%)</i>	<i>PCT dataset Freq. (%)</i>
Age		
Under 35	20 (27%)	50 (24%)
35-54	21 (28%)	80 (38%)
55+	34 (45%)	52 (25%)
Missing/ Decline to State	0 (0%)	29 (14%)
Gender		
Female	46 (61%)	130 (62%)
Male	29 (39%)	78 (37%)
Missing/ Decline to State	0 (0%)	3 (1%)
Race		
BIPOC	35 (47%)	101 (48%)
White	36 (48%)	103 (49%)
Missing/ Decline to State	4 (5%)	7 (3%)
Education		
Some High School	0 (0%)	13 (6%)
High School Grad	1 (1%)	44 (21%)
Some College	12 (16%)	50 (24%)
College Grad	25 (33%)	47 (22%)
Graduate/ Professional Degree	37 (49%)	18 (9%)
Missing/ Decline to State	0 (0%)	39 (18%)
Relationship with Physician		
Just met	52 (69%)	(no data)
Repeat visit	23 (31%)	(no data)
Initial Problem Type		
Musculoskeletal	33 (44%)	60 (28%)
Upper Respiratory	12 (16%)	65 (31%)
Other	30 (40%)	86 (41%)
N	75	211

Both datasets skew slightly female (approximately 60/40%) and are nearly evenly split between patients who identify as white and those who identify as non-white or BIPOC (black, indigenous or person of color). The patients in the AMH dataset are slightly older than the PCT dataset, and (perhaps relatedly) more highly educated. Because of the oversampling described above, the AMH dataset has a greater proportion of patients whose initial complaint was musculoskeletal (44%) than the PCT dataset (28%), with a correspondingly smaller proportion of upper respiratory initial complaints (16% vs. 31%). (Note that this statistic does not capture complaints presented subsequently to the initial one.) In the AMH dataset, 69% of patients were seeing the physician for the first time, though there is no comparative data from the PCT dataset.

1.3.3 Transcripts

Throughout the dissertation, extracts are transcribed according to standard conversation analytic conventions originally developed by Gail Jefferson (Atkinson & Heritage 1984; Hepburn & Bolden 2017) (see Appendix A). Focal patient turns are indicated with arrows in the margins. Focal physician turns are indicated with bold font. For easier reading, in-text quotations from extracts are simplified, i.e., conversation analytic conventions are removed. When relevant, I point out focal features verbally in the text, for example “rising-intoned” or “laughter-infused.”

1.4 OVERVIEW OF THE DISSERTATION

In this dissertation I examine how patients resist diagnostic assessments in primary care, how physicians respond, and the interactional processes leading up to diagnosis resistance.

1.4.1 A Note on the Concept of Resistance in Medical Encounters

When used in everyday talk, the term “resistance” often carries with it a sense of conflict or

overt disagreement. But resistance is not synonymous with disagreement. To say one is resisting advice, for instance, *may* but does not *necessarily* imply disagreement with that advice, overt or otherwise. Moreover, although resistance may foreshadow rejection of advice, it does not *constitute* that rejection (Heritage & Sefi 1992). Resistance can more generally refer to a reluctance to accept or go along with something, absent conflict or disagreement. This meaning introduces a much broader range of actions through which a person may *do* resistance, many of which are less overtly oppositional than direct disagreement. For instance, as Heritage and Sefi (1992) show, new mothers may resist the advice of health visitors merely by responding to their advice with unmarked acknowledgments like *mm hm*, declining to accept the advice or even treat it *as* advice, and foreshadowing – but, importantly, not *doing* – rejection of the advice.

As discussed throughout this dissertation, patients in primary care encounters are in a normatively subordinate epistemic position in terms of clinical matters and maintain an orientation to this position in how they communicate with physicians. Thus, we should not expect to see patients overtly disagreeing with physicians, nor outright challenging or rejecting their assessments or advice, with great frequency. This is why the concept of resistance *per se*, and the implications it has for the resources participants may use to engage in it, is so important.

A case in point is patient resistance to treatment recommendations. Although patients do sometimes question or challenge a physician's treatment recommendation, they more often – and typically *first* – resist that recommendation passively, through silence or unmarked acknowledgments like *mm hm* (Stivers 2005). And when patients do resist by more overtly challenging a physician's treatment recommendation, they tend to do so from within their own lifeworld domain of expertise, for example by citing their preferences, fears, or personal experiences (Stivers & Timmermans 2020). By doing so, patients avoid challenging or rejecting the physician's epistemic expertise underlying a treatment recommendation. Nonetheless, physicians hear in patient resistance a reluctance to go

along with their advice, and often pursue acceptance through treatment negotiation, where they work to persuade patients by addressing or countering their concerns (Stivers & Timmermans 2020).

As discussed earlier in this chapter, however, diagnostic assessments present a different interactional context than treatment recommendations. With treatment, patients are able to resist by withholding acceptance because physicians orient to patient acceptance as necessary before they can move on to some next activity. But this is not the case with diagnosis. When patients stay silent or minimally acknowledge a diagnostic assessment, this cannot accomplish resistance because acceptance is not treated as necessary in order for the visit to proceed. If patients have residual concerns about their condition or its assessment, they cannot rely on passive resistance as an interactional resource for interactionally “stopping the train” toward visit closing.

The operationalization I propose for diagnosis resistance in Chapter 2 captures a range of actions patients may use in lieu of passive resistance. As with other forms of resistance, almost none of these constitute explicit disagreement with, or rejection of, a physician’s assessment of the patient’s problem. Instead, patients raise questions, concerns, or descriptions of their illness experience that not only interrupt counseling and block the physician from moving forward, but also invite reconsideration of the fit between the physician’s assessment and the patient’s experience or expectations. These actions are multifaceted in their form, position, and how overtly a patient can be heard to be challenging a physician’s assessment, if at all. I consider them all to be forms of resistance – i.e., enactments of a reluctance to accept or go along with a diagnostic assessment. Absent the interactional possibility of merely withholding acceptance of a diagnostic assessment, these interactional roadblocks are a resource for patients to “stop the train” and work to have their lingering concerns addressed in a context of deep epistemic and interactional asymmetries.

Another reason the concept of resistance is important in this interactional context is that it allows for the possibility that a patient’s reluctance to accept or go along with a physician’s

assessment is not motivated by underlying disagreement or rejection of the assessment *per se*. When patients put up interactional roadblocks that invite reconsideration of their problem, they may not be doing so as a method for challenging or rejecting the physician's assessment or authority to diagnose. As I show in Chapter 4, patients' concerns regarding their condition or its assessment may remain unmet post-assessment for a variety of reasons, and diagnosis resistance often emerges out of some gap or lack of fit between the physician's assessment and the patient's expectations, illness experience, theories of their illness, and so on. Resistance does not necessarily index disagreement with the physician's assessment so much as reluctance to accept the assessment and move forward, pending closure of that gap.

Nonetheless, by in some way inviting reconsideration of the fit between the physician's assessment and the patient's experience after the shift to counseling, diagnosis resistance presents an implicit challenge to physicians' medical authority and risks undermining the nature and purpose of the visit. This is because, as discussed earlier, medical authority and the interactional structure of acute primary care visits are deeply intertwined. By combining the multifaceted variety of actions captured by my proposed operationalization together under the banner of "resistance," this study is able to examine not only how patients work to get their lingering concerns addressed post-assessment, but also, as I show in Chapter 3, the social and interactional challenges their actions present physicians and how physicians respond. In Chapter 5, I conclude by further drawing on my conceptualization and operationalization of resistance – and the array of actions it captures – to think more about what my findings mean for physician authority, patient engagement, and the pursuit of more patient-centered healthcare delivery.

1.4.2 Chapter 2

In Chapter 2 I draw on key conversation analytic concepts related to the intersection of

authority and interaction in medical visits – epistemic asymmetries between physicians and patients and corresponding interactional asymmetries at both the local and structural levels of the interaction – to operationalize and illustrate a definition of diagnosis resistance in primary care. This operationalization identifies resistance through a kind of objective hermeneutics turning on the structural organization of acute care visits and reversal of the visit from counseling back into information-gathering. It attends to what other conversation analysts have characterized as diagnosis resistance, but goes beyond what those studies have found in two key ways: it focuses on resistance to *diagnostic assessments* rather than diagnoses *per se*; and it examines resistance beyond the turn(s) immediately following a diagnosis for resistance, looking instead at the entirety of the counseling activities, beginning at the shift from information-gathering and ending at visit closing.

Rather than focusing on a particular action or group of actions as resistant, my proposed operationalization instead focuses on the progressivity of counseling toward closing, defining as resistant any action which not only stalls but initiates reversal of the visit's progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped. This operationalization thus also brings into focus the interactional resource patients are ultimately drawing on to interrupt the progressivity of a visit in service of whatever lingering concerns they may have about how their problem is being assessed, absent the possibility of passive resistance.

One main finding resulting from my proposed operationalization of diagnosis resistance is that it occurs far more frequently than previously thought – as often as 4 out of 5 visits for new or acute health problems physicians have with patients in primary care. I find three main types of resistant actions in the data: those which substantively fall in the domain of clinical knowledge and are formatted as questions; those which substantively fall in the lifeworld domain and are formatted as assertions; and those which I argue cross domains by framing something substantively in one

domain, e.g., a symptom description, in the format of the other domain, e.g., a question. I argue that there is a cline here in the extent to which patients' actions threaten interactional and epistemic asymmetries, based on whether an action treads into the physician's domain of clinical expertise, and how strongly it constrains the physician to respond. I find that patients tend to resist diagnoses in the least overt ways, relying primarily on actions which fall in their own domain of lifeworld expertise and place the least constraints on physicians to respond. Patients also do extensive work to mitigate the inappropriateness of their resistant turns and the challenge they may present to the physician's authority. These findings suggest that patients are orienting to their resistance as potentially problematic, even if the purpose of that resistance was not to disagree with the physician's assessment or challenge their authority *per se*.

1.4.3 Chapter 3

In Chapter 3 I consider the social and interactional position diagnosis resistance puts physicians in and examine how they respond. Regardless of patients' underlying motivations for resisting accepting or going along with a physician's diagnostic assessment, by interrupting counseling to make a move to an activity context where the physician's assessment may still be shaped, they implicitly challenge physicians' interactional authority to have moved into counseling, as well as their epistemic authority to have assessed the problem in the first place. Diagnosis resistance also creates a response slot where reconsideration of the patient's problem, reassertion of the original assessment, or at least pursuit of the patient's concerns underlying their resistance is at least potentially relevant before resuming counseling activities. This move backward is happening in a context where physicians have limited time to spend with each patient and have already begun an observable move toward closing the visit.

I find three categories of physician response in the data: brush-offs, physician-centered

responses and patient-centered responses. With brush-off responses patient actions are interactionally bypassed without being treated *as* resistance. These actions typically afford the fastest return to the physician's interactional agenda. In contrast, physician- and patient-centered responses do treat a patient's actions as resistant, either by pushing back against it or to varying degrees aligning with the patient's invitation to return to information-gathering and/or reassessment. With physician-centered responses physicians work to move past the resistance and return to their clinical agenda as quickly as possible, while with patient-centered responses they work more expansively to acknowledge or address patient concerns before moving on.

After examining the patterning of these response types across visits, I argue that physicians tend to prioritize maintaining progressivity and their own agenda over responses that attend to or otherwise pursue patient concerns, which may in part be driven by institutional constraints, especially on the time physicians are allotted for patient visits. But this trend is also shaped by how patients resist in the first place, with physicians more likely to brush off the least overt types of resistance, which are themselves the most common. There is almost a sense of collusion between patients and physicians to keep diagnosis resistance off-record and to protect the progressivity of the visit from being too compromised by it. But, as I show at the end of the chapter, patients are in general more likely to pursue response to their resistance than to abandon it, and this trend is strongest following brush-off responses. This suggests that whatever lingering patient concerns are driving diagnosis resistance, they are still not being addressed.

1.4.4 Chapter 4

In Chapter 4 I explore the interactional processes leading patients to resist physicians' diagnostic assessments, both in individual visits and across primary care visits more generally. Examining the wider interactional context of acute care visits – i.e., what happens *before* possible

moments of resistance – I identify commonalities among cases where resistance occurs, and contrast these with cases where it does not. I argue that diagnosis resistance occurs in cases where there is observable *divergence* between patients’ and physicians’ assessment of the patient’s problem. Once counseling begins and the physician’s assessment is no longer ostensibly under development, divergence solidifies into a gap between patient concerns and how the physician is addressing them, which will persist through visit closing absent some move to reopen assessment activities. It is out of this gap that I argue diagnosis resistance emerges.

In contrast, visits where patients do not resist are characterized by convergence between patients’ and physicians’ assessment of the patient’s problem. This finding suggests that patient resistance can only be mitigated when, to put it unceremoniously, patients get what they want, or their theories are confirmed. There are, however, a small subset of cases where there *is* observable divergence but no later resistance. In these cases, physicians have done work to bridge the resulting gap by explaining their clinical reasoning in a way that ties to the patient’s concerns. This may point to one way physicians can mitigate resistance even in contexts of divergence. But, as illustrated in the extracts I examine, patients rarely explicitly communicate their underlying concerns or assessment of their problem in the beginnings of visits, instead deferring to the physician to determine how to relevantly address their problem. Moreover, physicians rarely explicitly pursue patient concerns.

Taken together, the findings from this chapter underscore recommendations from patient-centered care scholars that physicians should actively pursue not only the biomedical aspect of a problem, but also the patient’s perspective, including their expectations, feelings, theories, and concerns about that problem. Such recommendations still remain more of an aspiration than a clinical reality, but this would help physicians address those concerns later, especially in contexts where their assessment is divergent from how the patient sees their problem. This could potentially mitigate the effects of divergence, reduce the overall rates of diagnosis resistance in primary care,

and improve patients' experiences with their healthcare.

1.4.5 Chapter 5

In the conclusion chapter of this dissertation, I reconsider the findings from all three of these chapters, revisiting some of the concepts outlined in this introductory chapter related to traditional medical authority and its reflexive relationship with the interactions through which medical care is delivered. I argue that there is a tension between patient engagement and a legacy of paternalism when it comes to diagnostic assessment, such that patient engagement via diagnosis resistance threatens physicians' traditional epistemic authority to assess the patient's problem; but conversely, participants maintain an orientation toward that authority, which undermines patient efforts to get their concerns addressed.

CHAPTER 2:

Operationalizing diagnosis resistance in acute care encounters

2.1 INTRODUCTION

Diagnosis resistance is distinct from other types of patient resistance in primary care because of the epistemic status of diagnostic assessment and the structural position it occupies in clinical encounters. A physician's assessment of a patient's problem is necessarily prefatory to clinical action, and provides the basis upon which such action is recommended or carried out (Starr 1982). This includes both official medical diagnoses, as well as the broader and sometimes less clearly defined ways physicians assess patients' problems in primary care. The authority physicians draw on to assess a patient's problem is the epistemic authority to define the nature of the situation (Starr 1982; Heritage & Raymond 2005; Heritage 2012), which represents a "fulcrum in the exercise of medical authority" (Heritage 2005b). Whereas physicians and patients orient to treatment and other clinical actions as "a domain of shared, though not equal... rights and responsibilities" (Stivers 2007:106), they do not treat diagnostic assessment the same way. This difference in orientation shapes the interactional resources patients may draw on to resist diagnostic assessments versus clinical actions like treatment.

When physicians recommend treatment, they wait for overt patient acceptance before moving toward visit closing (Stivers 2005, 2006, 2007; Koenig 2011). As a result, patients can resist treatment recommendations actively – by questioning or challenging the recommendation – *or* passively, by merely withholding acceptance and preventing the physician from moving forward (Heritage & Sefi 1992; Stivers 2005, 2006, 2007; Koenig 2011). In contrast, when physicians deliver a diagnostic assessment, they often move toward the next activity without waiting for a response (Heritage & McArthur 2019); and in some cases, they never explicitly discuss their assessment in the

first place, and so there is nothing for patients to respond *to* (Heritage & McArthur 2019). Whether or not patients overtly accept a physician's assessment of their problem has no impact on visit progressivity (Heath 1992; Stivers 2007; Heritage & Clayman 2010; Koenig 2011). Patients therefore have no options for passive resistance like silence and minimal acknowledgements and can only resist diagnostic assessments through substantive turns at talk. Diagnosis resistance may thus present a greater interactional challenge for patients than other types of resistance.

Some of the ways conversation analysts have shown patients to resist diagnostic assessments in primary care include overtly rejecting a diagnosis (Peräkylä 2002, 2006), calling a physician's diagnostic inference into question (Stivers 2007), questioning the evidence upon which a diagnosis is based (Peräkylä 2002; Stivers 2007), (re)proposing a candidate or alternate diagnosis (Peräkylä 2002, Stivers 2007, Ijäs-Kallio et al. 2010), invoking information received in a past medical visit or experience with a similar illness in the past (Ijäs-Kallio et al. 2010), and (re)describing symptoms (Heath 1992; Peräkylä 1998, 2002; Ijäs-Kallio et al. 2010). When delivered in direct response to a diagnosis, these actions overtly resist that diagnosis because they prevent the physician from moving to some next activity by challenging or calling into question the physician's assessment or offering information that may encourage reassessment.

According to Heath (1992), Peräkylä (1998, 2002, 2006), Stivers (2007), and Ijäs-Kallio and colleagues (2010), diagnosis resistance is rare in primary care. This suggests that primary care patients are either accepting physicians' assessments at face value, or at least not outwardly resisting them, which could be explained by patients' general orientation to physicians' epistemic authority. The rarity of diagnosis resistance may also be one factor underlying the general perspective in medical sociology that, unlike the erosion of the medical profession's authority over other aspects of clinical practice, physicians' epistemic authority to assess patients' problems in clinical encounters remains fairly stable (e.g., Stivers & Timmermans 2020).

However, the finding that diagnosis resistance is so rare may be shaped by the interactional position where conversation analysts normally look for it in the first place. Existing studies only look at instances of resistance produced in immediate response to explicit diagnoses. This means resistance to assessments that do not include explicit diagnoses are not captured. Moreover, some of these same studies have found that primary care patients in general rarely respond to diagnoses more than minimally, if at all (Heath 1992; Peräkylä 2002, 2006; Heritage & McArthur 2019). This may suggest that patients are waiting to hear the upshot of a diagnosis before they comment. But any immediate response beyond minimal acknowledgment or acceptance may also be hearable as a direct challenge, especially if it is delivered before the physician has arrived at any sort of upshot (Heritage & McArthur 2019). Patients may therefore withhold more expanded responses to diagnostic assessments, opting instead for some later action that less overtly challenges the physician's authority, or less directly impedes the physician's ongoing project (see also Gill 1998; Gill & Maynard 2006).

Indeed, in recordings of primary care visits of the sort used in prior studies, as well as this dissertation, one can find some of the same actions characterized as diagnosis resistance even in cases with no explicitly named diagnosis, and long after the moment of diagnostic assessment has passed, including during or after treatment discussions and into visit closings. Despite their reduced proximity to the assessment, such actions may nonetheless be resistant, and should be captured in an analysis of the ways patients go about questioning physicians' assessments.

In this chapter I propose a novel operationalization of diagnosis resistance that draws on what we know about the interactional structural organization of acute care visits in primary care, the position diagnostic assessment occupies within it, and how patients may – sometimes rather subtly – disrupt that organization in ways that resist accepting the physician's assessment and going along with counseling activities based upon it. This operationalization brings into focus the interactional

resource patients are ultimately drawing on to interrupt the progressivity of a visit in service of whatever lingering concerns they may have about how their problem is being assessed. It also liberates the analysis from the confines of the response slot in explicit diagnosis sequences, capturing a wider variety of resistant actions occurring at any point following a diagnostic assessment up to and including visit closings, including in cases where diagnosis is not explicitly discussed. I find that diagnosis resistance occurs far more often than previously thought, suggesting that patients do have lingering concerns about their condition and its assessment, and are doing some work to get those concerns addressed.

In the first part of my analysis, I work through how to identify resistant actions based on my proposed operationalization, initially lumping all resistant actions together in order to demonstrate how the operationalization works. In the second part I analyze noteworthy differences between the types of actions it captures in terms of epistemic domain and format. I argue that resistant actions vary along a cline in the extent to which patients' actions threaten interactional and epistemic asymmetries, based on whether an action treads into the physician's domain of clinical expertise and how strongly it constrains the physician to respond. I find that, although patients are resisting physicians' assessments more often than previously thought, they are doing so carefully, relying primarily on actions which substantively fall in their own domain of lifeworld expertise, and which interactionally place the least constraints on physicians to respond. Patients also do extensive work to mitigate the inappropriateness of their resistance in terms of the ongoing flow of the interaction, and the implicit challenge their resistance may present to the physician's authority. These findings suggest that patients are orienting to their resistance as potentially problematic, even if the purpose of that resistance was not to disagree with the physician's assessment or challenge their authority *per se*. The implications of these findings will be discussed in more depth at the close of this chapter.

2.2 BACKGROUND

In the conversation analytic literature there are some family resemblances among actions that are considered resistant, but there is variation between studies in what actions are discussed and how resistance is characterized in the first place. For Heath (1992) diagnosis resistance comprises stalling progressivity of the diagnostic sequence by introducing matters that are typically dealt with during information-gathering phases, effectively encouraging the physician to reassess the patient's complaint. For Peräkylä (2002), resistance includes actions which reject or show disalignment with a diagnostic assessment, through which patients assume some agency in the diagnostic decision-making process. For Stivers (2007), diagnosis resistance involves stalling progressivity to treatment by initiating new sequences which call into question or disaffiliate with the diagnostic evaluation. Finally, for Ijäs-Kallio, Ruusuvoori and Peräkylä (2010), diagnosis resistance involves actions that argue or imply that there is a different diagnostic possibility, or that confront/ contradict the diagnostic assessment.

There are two primary components of diagnosis resistance that can be drawn from these accounts. The first is the epistemic component, where diagnosis resistance involves rejecting or calling into question the physician's diagnostic assessment. The second is the interactional component, where diagnosis resistance involves stalling the physician's progressivity from diagnostic assessment to treatment and ultimately closing. Both components of diagnosis resistance are underpinned by and threaten to disrupt corresponding epistemic and local interactional asymmetries characteristic of medical encounters. In this section, I discuss each of these, and then add a third component that has been neglected in the literature, on which my proposed operationalization of diagnosis resistance turns: structural interactional asymmetries.

2.2.1 *Epistemic Asymmetries in Primary Care*

When patients present health problems to physicians, they tacitly set in motion epistemic and interactional asymmetries through which they defer to the physician to investigate and diagnose their problem on their behalf. As conversation analysts have shown, these asymmetries are not hard-and-fast rules; rather, they are norms that are enacted and oriented to by both physicians and patients as part of their joint project toward an accurate diagnosis and treatment (Pilnick and Dingwall, 2011).

The notion of epistemic asymmetries refers to how participants in medical encounters orient to patients' primary rights to expertise about their own life experience and to physicians' primary rights to clinical expertise (Meehan 1981; Gill 1998; Stivers 2002a; Heritage & Robinson 2006a; McArthur 2018). Patients' "epistemic domain" (Kamio 1997; Stivers & Rossano 2010; Heritage 2012) encompasses knowledge the patient would have primary access to regarding their illness experience, and physicians' epistemic domain encompasses knowledge the physician would have primary access to through medical training and experience in the field.

Of course, patients are no doubt capable of deploying their own medical knowledge and have been shown to participate in diagnostic reasoning in primary care visits (e.g., Gill 1998; Gill, Pomerantz & Denvir 2010). However, sociologists have long theorized that, although diagnostic reasoning may not be inherently opaque for patients (as Parsons [1951] proposed), it is *normatively* opaque (Freidson 1970a,b; Starr 1982; Peräkylä 1998). This notion refers not to patients' actual inability to understand what the doctor is doing or have theories of their own, but rather to their orientation to having diminished rights to understand or participate in diagnostic reasoning. This orientation shows up in the data time and again. When patients engage in actions that cross into the clinical domain, for instance using medical jargon (Meehan 1981), making diagnostic suggestions (Gill 1998; Stivers 2002a; Heritage & Robinson 2006a), and volunteering unasked-for information

during information-gathering (Stivers & Heritage 2001; McArthur 2018), they do so in ways that actively defer to the physician's clinical expertise, enacting an asymmetrical relationship (see also ten Have 1991; Heritage 2005a; Pilnick & Dingwall 2011).

When patients resist accepting or going along with a physician's diagnostic assessment, however mildly, their action presents an implicit challenge to the physician's expertise and authority to engage in clinical reasoning on the patient's behalf, and risks disrupting the normative epistemic asymmetries they tacitly set in motion by coming to the doctor in the first place. This is the epistemic component of existing accounts of diagnosis resistance.

2.2.2 Interactional Asymmetries in Primary Care

Interactionally, participants orient to physicians' primary rights to steer the visit in two ways: locally and structurally. These types of interactional asymmetries are closely linked and may not in all circumstances merit splitting. The distinction is relevant here because existing accounts of diagnosis resistance turn primarily on *local* interactional asymmetries, while my proposed operationalization turns on *structural* interactional asymmetries. It is indeed this shift that liberates the analysis from the position immediately following a diagnosis, and therefore captures so much more resistance.

2.2.2.1 Local Interactional Asymmetries

Local interactional asymmetries have to do with speakers' comparative rights to initiate new turns and sequences – that is, turns which are relatively unconstrained by a prior turn, and which condition a response or at least make one relevant (Linell & Luckmann 1991; Robinson 2001a). In acute primary care encounters, as in other institutional contexts, patients have little normative opportunity to take such initiative (Linell, Gustavsson & Juvonen 1988; Frankel 1990; Waitzkin 1991; Drew & Heritage 1992). Even during the problem presentation, when patients may talk about

their problem in a relatively unconstrained way, initiative is granted by the physician through a problem solicitation (Heritage & Robinson 2006a,b), and taken away by a move to history-taking questions (Mishler 1984). During information-gathering, patient talk is further constrained to answering the physician's questions.

As with epistemic asymmetries, interactional asymmetries are not hard-and-fast rules, but rather norms that are enacted and oriented to by both participants as part of their joint clinical project. Patients have indeed been shown to engage in actions that threaten these asymmetries. For example, patients in primary care sometimes volunteer un-asked-for information during information-gathering to push back against a physician's line of reasoning or get information "on the table" that the physician has not obviously considered, but they format these informings as responsive to some prior question, maintaining an orientation to the physician's primary rights to take the initiative (Gill 1998; Stivers & Heritage 2001; McArthur 2018). In their follow-up questions, physicians typically maintain a biomedical focus, disattending the patient's added contribution (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992).

During counseling, patient talk is further constrained: where physicians were previously asking questions, they are now primarily informing. In this interactional context, which is the focus of this chapter, physician questions no longer provide patients with a structural resource to take substantive turns. Any patient action that does more than receipt information challenges the physician's rights to initiate new turns and sequences. Moreover, when patients initiate new sequences with response-relevant actions like questions, they further constrain the physician's subsequent talk by making a response conditionally relevant (Sacks, Schegloff & Jefferson 1974; Gill 1998; Schegloff 2007; Stivers & Rossano 2010; Gill & Maynard 2006).

When patients engage in actions described in the literature resistant to a diagnostic assessment – e.g., rejecting the assessment or providing more symptom information – these actions

threaten local interactional asymmetries, stalling the physician's progress from diagnosis to some next action or sequence. This is the interactional account of diagnosis resistance.

There are two problems with this account. First, stalling progress away from a diagnostic assessment may not constitute resistance *per se*. Some actions, for instance requests for more information or a prognosis, do not necessarily call a diagnostic assessment into question, as I will demonstrate in the first part of my analysis. Second, the notion of stalling forward movement away from a diagnostic assessment is what tethers analyses to explicit diagnosis sequences, because it cannot be accomplished at any distance from a diagnosis, when the physician has already successfully moved on and participants are engaged in some other activity. This is where structural interactional asymmetries come in.

2.2.2.2 Structural Interactional Asymmetries

In contrast to local interactional asymmetries, structural asymmetries are enacted at the level of topic or activity (see also Linell & Luckmann's 1991 'global' asymmetries). Primary care encounters for new or acute problems are characterized by a normative succession of six activity phases: opening, problem presentation, history-taking and physical examination, diagnosis, treatment, and closing (Byrne & Long 1976; Robinson 2003; Heritage & Maynard 2006a,b; Koenig 2011). Movement from one phase to the next is normatively directed by physicians (Drew & Heritage 1992), who have long been described by medical sociologists as controlling the topic and flow of information in clinical encounters (Mishler 1984; Abbott 1988; Frankel 1990; Robinson 2001a). For instance it is the physician's first follow-up question that effects the transition from problem presentation to history-taking (Heritage & Clayman 2010), and it is usually the physician who initiates shifts into and out of physical examination, e.g., through movement toward and then away from the patient's body (Heath 1986; Robinson & Stivers 2001; Heritage & McArthur 2019),

explicit requests like “shall I have a listen to your chest” (Heath 1986) and invitations for the patient to sit on the exam table or return to their seat.

But as with epistemic and local interactional asymmetries, structural interactional asymmetries are locally managed norms, not hard-and-fast rules. Patients can, and do, engage in actions that initiate movement from one activity phase to another themselves. Such movement may be forward or backward. Initiating forward movement may include, for example, attempting to close the problem presentation through ‘exit devices’ like “so I figured I better come in to see what it could be” (Heritage & Clayman 2010); presenting a part of their body for physical examination during the problem presentation (Robinson & Stivers 2001; Robinson & Heritage 2005) or requesting an assessment during information-gathering (e.g., “so what do you think?” or “could it be X?”). Backward movement is usually initiated by doing some action that belongs in a prior activity phase. This has not been directly addressed in the literature, but patients can be seen to initiate backward movement when, as Heritage and Clayman (2010) show, they return to their problem presentation *after* the physician has asked a history-taking question.

It’s important to point out that although patients may *initiate* transition from one activity phase to another through these actions, they cannot *effect* the transition – forward or backward – on their own; a physician must align with that movement in order for activity transition to occur. Nonetheless, any time patients make a move to a different activity phase, they challenge the physician’s structural interactional authority to initiate such transitions, and their epistemic authority to decide *when* to transition. I argue that diagnosis resistance does something similar, but in a way that risks striking more directly at the heart of the physicians’ medical authority and the reason for the visit. This has to do with the position diagnostic assessment occupies within the structural organization of primary care visits.

The six normative activity phases of acute care visits can be grouped into two broader

activity types: information-gathering, where the physician is gathering information from the patient (problem presentation and history-taking/exam), and counseling, where the physician is giving information to the patient (diagnostic assessment and treatment, including talk about testing, prognosis, etc.). At the center of this activity structure, the moment around which the transition from information-gathering to counseling pivots, is the diagnostic assessment. Although a physician's actual mental assessment is not observable, in interactional terms information-gathering activities are recognizably leading up to a moment of assessment, and counseling activities are recognizably subsequent to and contingent on one. Initiating backward movement across this line is not the same as initiating transition across any other activity phase boundary, because it crosses from post-assessment activities to an activity context where the physician's assessment may still be shaped, treating that assessment as unsettled. This is what I argue diagnosis resistance is implicitly doing, even if patients are not directly disagreeing with or rejecting a diagnostic assessment.

The most overt forms of diagnosis resistance described in the literature – e.g., rejecting or questioning a diagnosis – do directly challenge the physician's assessment. With these actions, which are rare, it is the rejection of the assessment itself that initiates or makes a bid for a return to information-gathering activities. But I argue that the reverse is also true: when patients raise questions, concerns, or descriptions of their illness experience that not only interrupt counseling and block the physician from moving forward, but also invite reconsideration of the fit between the physician's assessment and the patient's experience or expectations, they effectively resist the physician's assessment. This is where my proposed operationalization comes in.

2.2.3 Proposed Operationalization of Diagnosis Resistance in Primary Care

Based on concepts discussed in the foregoing discussion, I operationalize diagnosis resistance as *any patient action which, at any point during counseling, not only stalls but initiates reversal of the*

visit's progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped. This operationalization identifies resistance through a kind of objective hermeneutics turning on the structural organization of acute care visits and reversal of the visit from counseling back into information-gathering. Heath (1992) indeed noted that some types of diagnosis resistance may do this. What is novel about my operationalization is that initiating reversal of the visit's progressivity is *definitional* of diagnosis resistance; it is a necessary and sufficient condition. It is also important to note that, as discussed in Chapter 1, although actions thus defined as resistant enact a reluctance to accept or go along with a diagnostic assessment, they do *not* necessarily index disagreement or rejection of that assessment. Nonetheless, by in some way inviting reconsideration of the fit between the physician's assessment and the patient's experience after the shift to counseling, diagnosis resistance presents an implicit challenge to physicians' medical authority and risks undermining the nature and purpose of the visit.

This operationalization is analytically useful for a number of reasons. First, it captures resistance of diagnostic assessments that do not consist of an explicit diagnosis *per se*. As discussed in Chapter 1, primary care physicians' assessments of patients' conditions go beyond diagnosis specifically, and may include assessments that, e.g., the patient's problem is not very serious, that it's *not* a particular diagnosis (e.g., rule-outs), that diagnosis is irrelevant and uncertainty acceptable, and so on. A physician has ostensibly arrived at some kind of assessment the moment they initiate the transition from information-gathering to counseling, and that assessment underpins – and, for patients, may be inferable through – the physician's explanations and suggestions throughout counseling. By focusing on how patients initiate reversal of the visit's progressivity out of counseling, one can see the myriad ways patients may resist an assessment without targeting an explicitly stated diagnosis *per se*.

Second, this operationalization liberates the analysis from the confines of the response slot

in diagnosis sequences, capturing resistant actions occurring at any point following a diagnostic assessment up to and including visit closings.

Third, by shifting its focus to a consideration of structural interactional asymmetries and the concept of renewing the relevance of diagnostic inquiry, this operationalization is one level of abstraction removed from individual actions. As such, my proposed operationalization is unitary – capturing the various actions already described in the literature; expansive – allowing new resistant actions to be identified; and generative – enabling other analysts to identify instances of resistance even if what they see in their data does not look like what has been illustrated in this dissertation. It also brings into focus the interactional resource patients are ultimately drawing on to interrupt the progressivity of a visit in service of whatever lingering concerns they may have about how their problem is being assessed.

In the following analysis I work through how to identify resistant actions based on my proposed operationalization, initially lumping all resistant actions together in order to demonstrate how the operationalization works. I then examine noteworthy differences between the types of actions it captures in terms of epistemic domain and format, arguing that resistant actions vary along a cline of overtness based on whether an action treads into the physician's domain of clinical expertise and how strongly it constrains the physician to respond. I show that patients in fact resist diagnostic assessments in primary care far more often than previously thought, but that they do so carefully, relying primarily on less overt actions in their own domain of lifeworld expertise which place the least constraints on physicians to respond, and doing work to mitigate the inappropriateness of their resistant turns and the implicit challenge they may present to the physician's authority.

2.3 DATA

As in all chapters in this dissertation, this chapter draws on both the PCT and AMH datasets for observations and illustrative extracts, while all distributions and statistics are drawn from the AMH dataset. In this chapter my unit of analysis consists of individual instances of resistance, of which there are sometimes multiple across a single counseling session. In the AMH dataset there are 183 discrete instances of resistance. This number will be further broken down into distributions of different types of resistance throughout the analysis.

In the following analyses I exemplify types of resistance through short excerpts focusing on the action itself, with only brief comments on the wider interactional context when necessary. Ultimately, understanding what patients are doing through these actions requires a more thorough examination of them *in situ*. For example, they are often produced in series over the course of a counseling session, and many are observably lodged within broader patient projects to achieve some particular goal, for example to receive a specific diagnostic test. Such features of the actions exemplified here, and their implications for physician response, will be analyzed in subsequent chapters.

2.4 ANALYSIS

2.4.1 *Building the Collection*

In this section I explain in detail some of the inclusion and exclusion criteria for building a collection of diagnosis resistance based on my operationalization.

2.4.1.1 Position

For inclusion in the collection an action must occur during the counseling phases of the visit, subsequent to the “slot” where a diagnosis might normally occur. Following Heritage and

McArthur (2019), I looked for this slot in the turn(s) immediately following the close of the physical examination or, in cases where an on-site diagnostic test is performed, when the physician rejoins the patient in the room following the test. When there were additional intervening activities (e.g., handwashing) I looked to the next substantive turn at talk. When the physician or patient initiated talk about a separate topic, I looked to the next turn at talk recognizably re-engaging the topic of the patient's problem. Not all diagnosable problems are ultimately diagnosed in primary care, and even in cases where there *is* a diagnosis, it is sometimes named at some point subsequent to the normative diagnosis slot (Heritage & McArthur 2019). But whatever is delivered in this slot – e.g., diagnosis, recommendations for tests or treatment, uncertain diagnostic talk, etc. – is hearably informed by an assessment of the patient's problem, and marks a shift from information-gathering to counseling. Diagnosis resistance can occur at any point following this transition, up through visit closings.

2.4.1.2 Action

My proposed operationalization does not specify any action type *per se*. Indeed, as I show later in this and subsequent chapters, patients may resist a diagnosis through a variety of actions and formats, which have implications for how strongly they risk being heard to challenge a physician's authority to assess the problem, and how the physician might respond. For inclusion in the collection, actions must merely initiate reversal of the visit's progressivity out of counseling, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped.

To find such actions in the data, I first identified any patient action during counseling that went beyond merely receipting information from the physician or, when relevant, answering a physician's question. I then worked through these actions, selecting for the collection only those that could be argued to move backward in the visit by renewing the relevance of information-gathering.

The most overt forms of resistance, for example rejecting or questioning a diagnosis, directly challenge the physician's diagnostic assessment, necessarily inviting further inquiry and reassessment. This is illustrated in Extract 1.

This extract illustrates the most overt form of diagnosis resistance in the data. In this visit the patient has presented with pain in her heel. She has seen other physicians for this problem but says "I just don't think we're getting to the bottom of the problem because I still can't walk on my foot" (not shown). When the physician asks if she has tried steroid injections for the pain, she says "but we don't even know what it is yet, no x-rays or nothing" (not shown). After examining the patient's foot, the physician moves into counseling with "well it's been diagnosed before as plantar fasciitis" (not shown). This is not a new diagnostic assessment, as it merely asserts a prior clinician's diagnosis. Nonetheless, it reveals the physician's alignment with that diagnosis, and his assessment that further diagnostic inquiry or reconsideration of the diagnosis is not necessary. After some explanation of this diagnosis – e.g., that the muscles in the foot are a fibrous band attached to the heel that stiffen with age – he recommends treatment. In the extract below, the physician is in the middle of recommending foot massage with a water bottle when the patient asks, "are we sure that's what I have?" in line 3.

(1) PCT 21-06 Counseling

```
1 DOC: Well (.) here's what could work well. .pt .hh
2 Get a bottle of water. (0.5)
3 PAT: -> Are we sure that's what I ha:ve?
4 (0.5)
5 DOC: Yeah.
```

This turn threatens all three asymmetries described at the outset of this chapter – local interactional asymmetries, epistemic asymmetries, and structural interactional asymmetries. First, because this question is initiated as a new action during counseling – indeed, in interjacent overlap (Jefferson 1984d) with the physician's treatment-related turn – and makes response conditionally

relevant, it stalls the progressivity of the current activity. The patient uses this interactional space to explicitly question the diagnostic assessment, which overtly challenges the physician's epistemic authority to diagnose.

We could stop here, because questioning the diagnostic assessment in this way obviously resists it accepting it. However, the proposed operationalization does *not* require actions to present such an overt challenge to a diagnostic assessment to count as resistance. Rather, it merely requires that actions invite reconsideration of the patient's problem by initiating a return to information-gathering. Cases like this, where a diagnosis is obviously challenged, necessarily do this. But such cases are exceedingly rare. More often, the reverse is true – a diagnostic assessment is not overtly challenged, but it is nonetheless resisted because a patient renews the relevance of diagnostic inquiry, for example (re)describing symptoms. Extract 2 illustrates this.

In this visit the patient has presented with upper respiratory symptoms including congestion and coughing. Following information-gathering the physician delivers a diagnosis of “a little sinus infection” in line 1, followed by some explanation casting “fullness in the nose” as the “first line of defense” in the progression of the patient's illness. In response to this the patient volunteers “I've been stuffed up for a long time” in lines 5-6.

(2) AMH 03-04 Diagnosis into counseling

```

      ((DOC facing PAT to deliver Dx))
1  DOC:  .h So >I think< you got a little sinus infection,=
2        You got a lot of fullness in the no:se. .hh So
3        that's your first line of defense. So as that
4        [stuff comes i:n, (0.2) your body sort of rea:[cts,
5  PAT:  -> [Yeah.                                     [I've
6        -> been stuffed up (0.2) [f- for a l:ong time.
7  DOC:                                     [Yeah.
8  DOC:  Yea:h and then you can get that post-nasal drip. So
9        that's [(in the chest and the cough there.) .hh U:m
10 PAT:  [(causing cough,)
11 DOC:  hh .t a:nd it's been how many:- how many: [weeks
12 PAT:                                     [The n-
13 DOC:  [that you said the stuffiness [and the congestion,
14 PAT:  [the: s-                               [the stuffiness and
15        congestion has been since a week ago Monday at [least.
16 DOC:                                     [Okay.
```

By volunteering information normatively given to a physician during the information-gathering phases preceding counseling, the patient initiates reversal of the visit's progressivity by renewing the relevance of diagnostic inquiry. In this case, the physician indeed returns to information-gathering by asking "and it's been how many weeks that you said the stuffiness and the congestion..." in lines 11-13. This crosses from post-assessment activities to an activity context where the physician's assessment may still be shaped, treating the assessment as unsettled. In cases like this, the patient's action does not directly challenge the physician's diagnostic assessment. Nonetheless, by renewing the relevance of diagnostic inquiry, the patient resists accepting the physician's assessment, presenting an implicit challenge to the physician's medical authority.

In Extract 2 the patient's action has indeed resulted in reversal of the visit's progressivity into pre-assessment activities, because the physician responded with further history-taking questions. However, as I discuss at length in the next chapter, physicians often respond to diagnosis resistance in ways that maintain or quickly restore the visit's progressivity toward closing, without returning to information-gathering. This is illustrated in Extract 3.

In this visit the patient presented with multiple problems, one of which is a burning sensation in her hands and feet. The physician delivered an uncertain diagnostic assessment, saying that "there may be some neuropathy, but there could also just be some forearm tendonitis and stuff that's messing you up" (not shown). He then recommended blood tests "to make sure there isn't something else going on, like something inflammatory or something related to vascular issue," but added "which I don't think is the case" (not shown). Towards visit closing the physician recommends a follow-up visit, accounting for this recommendation with "we'll probably have things to talk about because of all the different symptoms you have" in lines 1-2. The patient responds with "I come across as like a wreck," adding additional symptom information in lines 8-10 with "like right now it's just like burning in here and it's just like ahhh," gesturing toward her forearm.

(3) AMH 02-18 Counseling

((Discussing follow-up visit))
1 DOC: We'll probably have things to talk about because of
2 all the (.) .h different symptoms you ha:ve,
3 PAT: Y:ea[:h.
4 DOC: [So d- I think it's best to [come in.
5 PAT: [I come across
6 as like a wreck. >It's just like<
7 DOC: ((laughs)) Y(h)eah. [.h
8 PAT: -> [Like right no:w it's just
9 -> like it's kind of burning in here and it's just
10 -> like (.) ahhh ((gesturing toward forearms))
11 **DOC: Yea::h.**
12 (0.2)
13 **DOC: Yeah I know it is='n so um (0.8) so we'll get**
14 **to the bottom of [it. Okay?**
15 PAT: [Great. So am I doing the blood
16 test today too?
17 DOC: Yeah.

As in the prior extract, this symptom description initiates reversal of the visit's progressivity by renewing the relevance of information-gathering. In this case, however, the physician does not align with this reversal. Instead, he minimally acknowledges the information with "yeah" in line 11; casts it as already known with "yeah I know it is" in line 13; reasserts his prior course of action with "so we'll get to the bottom of it" in lines 13-14, referring to the blood tests he recommended; and pursues explicit patient acceptance and closure of this topic with "okay?" in line 14. These responsive action types are analyzed at length in the following chapter, but what is most relevant to note here is that the physician has shut down the patient's resistance and resumed progressivity toward closing (which the patient aligns with in lines 15-16: "so am I doing the blood test today too?"). Thus, unlike in the prior extract, the patient's action has not actually reversed progressivity. Nonetheless, her volunteered symptom information *initiated* reversal by renewing the relevance of diagnostic inquiry, making a move to an activity context where the physician's assessment may still be shaped. Such cases are included in my collection because this move in itself constitutes resistance of the diagnostic assessment.

2.4.1.3 A Note About Activity

Some of the actions captured by my proposed operationalization of diagnosis resistance resemble the kinds of prototypically resistant actions described in other conversation analytic studies, especially those that are done in direct response to a diagnosis, or within the context of talk that is diagnostic in nature. But the fact that patients can renew the relevance of diagnostic inquiry not solely in response to a diagnosis but at any point during counseling introduces the possibility that resistant actions may occur during *other* activities, for example during talk about prognosis, tests, referrals, treatment; during visit closings; and even during talk or activities related to entirely separate health concerns.

In some cases, as in Extract 1 (where the patient asked, “are we sure that’s what I have?” during treatment), patients are obviously bracketing off the local activity and returning to diagnosis. In other cases, the patient’s resistant action may be designedly *tied* to the ongoing activity, which I will show is one resource patients use to mitigate the inappositeness of their resistant turns and the overtness of their challenge to the physician’s authority. In still other cases, diagnosis resistance may be *bound up* in the ongoing activity. For instance, a patient may resist a diagnostic assessment as part of a broader project to push for an alternate treatment recommendation, referral, test, etc. Or a patient’s resistance may be bound up in a more local interactional project, e.g., defending the legitimacy of their decision to come to the physician in the first place. I discuss the connection between diagnosis resistance and patients’ projects, expectations, theories, and so forth in Chapter 4.

But regardless of the local activity, patients who observably renew the relevance of diagnostic inquiry are initiating a move to a context where the physician’s assessment may still be shaped, and thus resisting that assessment. The extent to which such actions are tied to or bound up with another ongoing activity may influence how directly the patient can be heard to be doing this. But it is analytically and interactionally relevant that whatever their underlying concern(s) or local

interactional project (observable, or perhaps inferable, or in some cases even hidden from view), patients are targeting the physician's diagnostic assessment *per se*. For instance, in a case where a patient resists a diagnosis of a virus as part of a bid for antibiotics, it is nonetheless relevant that she has chosen to challenge the diagnostic assessment upon which the treatment recommendation is based, rather than the treatment recommendation itself. Diagnosis resistance puts physicians in a distinct interactional position where they are being invited, however off-record, to reconsider the fit between their assessment and the patient's experience or expectations. This matters when we think about what the patient is accomplishing, and the range of resources a physician might use to respond, the focus of the next chapter. In sum, all actions which fit the proposed operationalization, regardless of local activity, are included in the collection.

2.4.1.4 Stalling Versus Reversing Progressivity

As discussed at the outset of this chapter, to truly resist a physician's diagnostic assessment, however mildly, a patient must in some way initiate reversal of the visit's progressivity by renewing the relevance of diagnostic inquiry. This operationalization omits actions which merely *stall* progressivity away from diagnostic assessment, such as queries *about* a diagnosis – what I am calling “contingent queries” – and newsmarks like “really?” which do not in and of themselves constitute resistance. Actions which merely stall but do not reverse progressivity are not included in my collection. Although such actions may foreshadow resistance, they may also be done “innocently,” in service of whatever interactional project they are on their face pursuing – i.e., understanding more about a diagnosis or prognosis, or treating a diagnostic assessment as unexpected – and nothing more. Extracts 4 and 5 illustrate this.

a. Contingent queries

When produced in immediate response to the diagnosis, contingent queries like questions about the diagnosis or prognosis expand the diagnosis sequence, preventing the physician from moving forward to the next counseling topic. Patients may also produce a contingent query at some later point in the visit, in which case they stall forward progressivity by returning to the diagnosis from whatever counseling activity was underway. In either case, patients disalign with the ongoing activity by initiating a new action and constraining the physician to respond. However, such questions do not on their face renew the relevance of diagnostic inquiry because they are contingent on, and thus presuppose, the physician's assessment. Extract 4 shows a patient querying a diagnosis "innocently," i.e., with no obvious project to ultimately resist.

In this visit the patient has presented with facial numbness, decreased taste sensations and dizziness. At the end of information-gathering, just after the physician examined the patient's nose and throat, he comments that there is some inflammation in her throat, and then delivers the first part of his diagnosis that "there's evidence of an infection here and it may be a viral infection" (lines 1-2). After explaining that infections can "affect the cranial nerves that help to move things in the face," he delivers in lines 16-17 a diagnosis of Bell's Palsy, which is temporary facial paralysis due to cranial nerve damage, widely believed to be caused by viral infections. There is a half-second silence in line 18, during which the physician and patient maintain mutual gaze but the patient neither nods nor changes her facial expression in any way. The physician is about to move on in line 19 ("h") when the patient asks "What's that" in 20.

(4) PCT 42-06 Diagnosis into counseling

1 DOC: So- so:=uh there's evidence of- of an infection her:e
2 and it may be a viral infection.
3 (0.5)
4 PAT: ((nods))
5 DOC: That's- that is- that is quite possible.
6 (0.5)
7 PAT: Mm hm,

8 (0.8)
9 DOC: And that's relevant because=h viruses could sometimes
10 also (0.5) a- affect=h the cranial nerves.
11 (.)
12 PAT: [((nods))
13 DOC: [tha- that (0.5) help with the face.=to move things in
14 the face.
15 PAT: Mm [hm.
16 DOC: [.pt .hh Ih-It looks like you have what we call
17 Bells Palsy.
18 (0.5)
19 DOC: [.h
20 PAT: -> [What's that.=
21 DOC: =Which means=hh the a- the seventh cranial ner:ve.
22 (0.2)
23 DOC: is being affected.
24 (0.2)
25 DOC: Th- [th- there- there's a whole bunch of nerves that
26 PAT: [°O:h, °
27 DOC: help (0.2) the- the fa:ce to do what it's supposed to.
((20 lines of explanation omitted))
28 DOC: So it- wh- what that means is you have some (.) of your
29 nerves being affected by [thee=uh .t .h the infe[ction.
30 PAT: [((nods)) [infection.
31 DOC: =that's pretty much what it means.
32 PAT: O::h.
33 DOC: .hh So what do we do for thi:s.=We put you on medication
34 to reduce the inflammation.
35 PAT: Oka:y,
36 DOC: And u::m a- hopefully: (0.2) that will bring it down to
37 a point where all your symptoms will resolve.
38 PAT: Ri:ght.

On its face this question requests an explanation or reformulation of the Bell's Palsy diagnosis. Indeed, this is what the physician provides in lines 21 through 31 (including 20 omitted lines), describing how infections can affect cranial nerves, causing motor and sensory deficits. Interestingly, by initiating this explanation with “which means” in line 21, the physician sequentially deletes the patient's question, tying his explanation to his own prior talk and thus marking his explanation as something he was going to do independently of the patient's question. He notably does not treat the patient as having called his diagnosis into question. In response to the physician's explanation, the patient displays shifts from non-understanding to understanding (*obs* in lines 26 and 32; *nods*; and a co-completion in line 14), orienting to the explanation as sufficient without revealing other underlying concerns.

In cases where diagnosis resistance does follow stalling actions like “what’s that,” it often emerges either during the sequence touched off by the question, or when the physician is observably bringing that topic to a close. In this visit, the physician brings his explanation to a close by moving on to a treatment recommendation in line 33 (“so what do we do for this...”). The patient aligns with this move to a new topic by accepting the recommendation for medication to reduce inflammation (*okay* in line 35), and the physician moves on to another topic, prognosis (“we do have to let you know that sometimes this can go on for months at a time... and uh sometimes you never get it back” in lines 39-42). He pursues uptake of this information by re-completing the prognosis in lines 45 (“time will tell”) and 47 (“this is just the early stages”). In the slot created by these pursuits, the patient asks another question, “and what would cause an infection like that” in line 48.

36 DOC: And u::m a- hopefully: (0.2) that will bring it down to
37 a point where all your symptoms will resolve.
38 PAT: Ri:ght.
39 DOC: Although (0.2) u:h we do have to let you know that
40 sometimes: this can go on for months at a ti:me,
41 (.)
42 DOC: .hhh a:nd=uh sometimes you never get it back.
43 (0.8)
44 PAT: M[m:..
45 DOC: [(Ih)=So:- so its (0.8) i::h on- time will tell:..
46 (0.5)
47 DOC: This is just the early stages.
48 PAT: -> .k .h And what would u::h cause an infection like that.
49 (1.2)
50 DOC: There are viral: organisms:=uh everywhere.
51 (0.5)
52 PAT: O:h.
53 (0.2)
54 DOC: u:h an- an:- (1.2) you know a virus.
55 PAT: ((sniffs)) Ri[ght
56 DOC: [A virus.
57 (1.0)
58 DOC: An- and it can affect (1.0) any any part of the
59 body:.=In this case it looks like it has affected (.)
60 uh (0.5) the cranial nerves.
61 (0.2)
62 PAT: [Yeah.
63 DOC: [.h .t
64 (0.2)
65 DOC: Ka:y so I- I’m going to put you o- on a anti-inflammatory
66 medica:tion.=You’re going to take that for two weeks.
67 PAT: Mkay.

By asking this question the patient again stalls progressivity by returning to the diagnosis. This question falls in the same category as the previous one in that it requests more information related to the diagnosis, presupposing that diagnosis without resisting it. The physician begins to answer by explaining where the virus may have come from in line 50 (“there are viral organisms everywhere”) before merely repeating his earlier explanation, that a virus caused the infection (“you know a virus... a virus” in lines 54 and 56), which affected her cranial nerves (lines 58-60). By doing so, the physician treats the patient’s question as motivated by the same underlying concern as “what’s that” – that she does not understand the diagnosis. Indeed, in cases of diagnosis resistance, when a patient’s concerns are not met the first time, there is often a subsequent action like this that makes a new attempt. In this case, however, the patient’s ‘concern’ always presupposes the diagnosis, and she never initiates reversal of the visit’s progressivity in a way that resists the physician’s assessment. Such cases are not considered diagnosis resistance.

b. Newsmarks

Other actions that stall but do not project reversal of the visit’s progressivity – and thus are not considered resistance – are newsmark, i.e., responses that treat an utterance as news such as *it is?* and *really?* Although patients may stall progressivity by producing newsmarks in response to all kinds of assertions during counseling, here my focus is only on those following diagnostic assessment-related assertions. These include “official” diagnostic utterances (Heritage & McArthur 2019) but are not limited to them. For example, one physician characterizes a patient’s itching as part of the “post-inflammatory process” after her immune system “won the battle” against shingles. The patient – who believes her itching means she still has shingles – responds, “did it?” This newsmark does not occur directly after a diagnosis but nonetheless stalls progressivity by requesting re-confirmation of the physician’s diagnostic assessment.

In general, newsmarks stall progressivity because they expand the ongoing sequence by requesting re-confirmation and, pragmatically, inviting expansion or revision of the physician's utterance (Jefferson 1981; Heritage 1984b). They contrast with other possible responses including silence, acknowledgment tokens like *mm hm*, and overt acceptances like *okay*, which maintain progressivity by passing on the opportunity to say more (Stivers 2007).

Newsmarks have been included in prior analyses of diagnosis resistance (Heath 1992; Stivers 2007), albeit the most minimal form. As a form of "ritualized disbelief" (Heritage 1984b), newsmarks treat assessment-related assertions not *merely* as informings but as news, i.e., as something other than what the patient expected (Heath 1992). Stivers (2007) considers that they index or at least foreshadow diagnosis resistance, particularly in the context of no-problem, no-treatment diagnoses. Indeed, Stivers found that most patients producing newsmarks in response to diagnoses later go on to more overtly resist the diagnosis. I have also found this to be the case. However, I argue that newsmarks are not *akin* to diagnosis resistance.

Newsmarks minimally request re-confirmation of a diagnostic assessment, and thus do not presuppose that assessment. In this way they are unlike contingent queries, which I have argued presuppose and thus implicitly accept a diagnosis. Further, by sequentially providing space for re-confirmation, newsmarks introduce the possibility, however unlikely, of *dis*confirmation. In ordinary conversation, speakers have been shown to in fact revise their original utterance following a newsmark (Jefferson 1981; Heritage 1984b). But revision is not the only thing newsmarks pragmatically invite; they also, perhaps more commonly, invite elaboration along some other line, e.g., an explanation or expanded telling (Jefferson 1981).

One thing shaping whether and what kind of expansion is invited is a newsmark's design. Jefferson (1981) illustrated that, for example, newsmarks syntactically formatted as interrogatives (e.g., "Do I?") are less likely to project disagreement than those that are not (e.g., "I do?" or "I have

tonsillitis?”). I argue that context also matters. Newsmarks may be strongly hearable as indexing resistance when they are produced in response to no-problem, no-treatment diagnoses, as in Stivers’ (2007) analysis, or more generally in response to diagnostic assessments that delegitimize the visit, minimize the patient’s problem, or are otherwise incongruent with the patient’s presentation of the problem – indeed, the contexts where diagnosis resistance is more common to begin with. In contrast, newsmarks produced in the context of a more serious diagnostic assessment may be heard to index unexpectedness but not resistance *per se*. This is illustrated in Extract 5.

In this visit, the patient tells a story about falling off his motorcycle and slamming his back against a thermos of coffee inside his backpack, causing severe pain. A few weeks later, he was tossing golf clubs into his truck, and aggravated the same injury, causing the pain he is currently in. During this telling, he implicitly orients to his problem as muscular by saying he “pulled something.” At the end of the physical exam, the physician instead diagnoses the problem as a cracked rib. The patient responds to this diagnosis with the newsmark “really” in line 4.

(5) PCT 25-08 Diagnosis into counseling

1 DOC: Kay:=You might have cracked=h (.) one of your ribs
2 over there.
3 (0.8)
4 PAT: -> hhh Really,
5 DOC: .hh It's a quite possibility.
6 (1.8)
7 PAT: °Yeah.°
8 (0.2)
9 DOC: Ka:y, n:- nonetheless the treatment is the sam:e.
10 (0.2)
11 DOC: .pt .kh I'm gonna give you some pain medication some
12 anti-inflammatory.
13 (1.5)
14 PAT: U:h (0.5) What kind of medication doc are we talking.
((omitted lines; doc now taking blood pressure))
15 DOC: When you're hurting:: (.) your pressure goes up.=
16 PAT: =I'll tell ya: I was in a lot of pain last night.
17 DOC: (Yeah,) ((clears throat))
18 PAT: -> You know I think you're right I think (1.8) I
19 might have hit it- (0.2) e:h you know I dented the
20 thermos I hit it so hard.=it was aluminum
21 thermos t[oo.
22 DOC: [((clears throat))
23 PAT: .hhh (0.2) I think you're right I think it's u:h

24 (0.2) a rib.
25 ((DOC continues taking blood pressure in silence))

Although this diagnosis is incongruent with the patient's earlier orientation to his problem as muscular, it is a problem (as opposed to no-problem) diagnosis that is not only congruent with his emphasis of the severity of his pain but is indeed more severe. The physician conveys some uncertainty about the diagnosis and then treats that uncertainty as irrelevant by moving on to treatment in lines 11-12. There is no further discussion of the diagnosis, and the visit moves to talk about the patient's high blood pressure. As the physician takes the patient's blood pressure, he mentions that "when you're hurting... your pressure goes up" in line 16. In response to this, the patient re-emphasizes the amount of pain he was in last night, which is a hearably on-topic corroborating account for his high blood pressure. However, he uses this as a stepwise transition (Jefferson 1984b) to revisit the earlier diagnosis of a cracked rib, adding "You know I think you're right... I think it's... a rib" in lines 18 through 24. This utterance reveals more explicitly that the patient originally had a different expectation for the diagnosis. It also represents a clear incursion into the physician's epistemic domain by treating the diagnosis as something with which to agree or disagree (Peräkylä 2002). Nonetheless, they are not resistance.

2.4.1.5 Other Exclusions

On rare occasions (n=4 in the AMH dataset), actions that fit my proposed operationalization are done as part of an observable project to support or agree with some aspect of the physician's diagnostic assessment, as in Extract 6. This patient presented with pain in his hips, which the physician diagnosed as hip flexor tightness. Following a recommendation for physical therapy the physician further explained hip flexor tightness, saying that it usually "is pain when you go from sitting to standing" in lines 1-2. It is in response to this that the patient explicitly agrees with the physician's characterization of his pain with "that's exactly what it is" in lines 3-4, and then

volunteers symptom information (an action type that fits within the operationalization of diagnosis resistance) that further demonstrates agreement in lines 6-13.

(6) AMH 05-04 Counseling

1 DOC: And the hip flexor tightness u:m is usually
2 pa:in [when you go from sitting to sta:nding.
3 PAT: -> [Mm. [That's
4 -> exactly what it [is.
5 DOC: [Ye[ah.
6 PAT: -> [Yeah that's (0.2) that's the
7 -> only time it hurts like I- I can sit and it doesn't
8 -> hurt.
9 DOC: Yeah.=
10 PAT: -> =And I can: n:- (0.2) you know like run [and it
11 DOC: [Mm.
12 PAT: -> doesn't hurt it. ((laughs)) but (0.2) when I
13 -> stand up it's like gr::ah ((laughs))
14 DOC: [Yeah. .hh so they- a
15 lotta s- a lotta times they use ba:nds,

Peräkylä (2002, 2006) points out that patients who agree with a diagnosis claim rights or abilities to engage in diagnostic reasoning and thus somewhat move into the physician's domain of clinical expertise. Nonetheless agreeing actions do not present the same social and interactional challenges to physicians' ongoing counseling projects as resistant ones and should not "count" as diagnosis resistance; in this analysis such actions were excluded from the collection of diagnosis resistance.

2.4.1.6 The Final Collection

A given patient action that fits my proposed operationalization is considered a discrete "instance" of diagnosis resistance once a turn is complete and a physician has an opportunity to respond. When patients compress or obscure a transition relevance place to add more, even if they're adding new or additional information, it is considered a continuation of the same instance of resistance. However, if there is a normal transition space and the physician has an opportunity to respond, any subsequent actions meeting the definition of diagnosis resistance is counted as a new instance. This coding decision is motivated by the interactional consequences of this for the

physician – each time a patient completes a new turn that can be defined as diagnosis resistance, a physician is faced with yet another “slot” where they must figure out how to address or deal with the patient’s backward movement.

In some cases of persistent resistance, a non-first instance of resistance follows a prior one closely, and can be seen to pursue a different or more substantive physician response; in other cases, pursuits occur more distally, where a patient resurrects resistance after some amount of intervening talk. Chapter 3 deals more fully with such sequences of persistence resistance. Actions that merely pursue response to a prior instance of resistance without adding anything more – e.g., turn increments, tag questions – are not considered additional instances of resistance. In total, there are 183 instances of resistance in the AMH dataset. This is the number of cases used in distributions throughout the remainder of this chapter.

Of the 75 videos in the AMH dataset, 60 contain at least one instance of diagnosis resistance. This is 80% of visits, which means that, if my dataset were to represent a primary care physician’s working day, they might encounter diagnosis resistance in 4 out of every 5 visits for new and/or acute health concerns. Of the 122 diagnosable problems across this dataset, 70 (57%) are resisted at least once; 42 (34%) are resisted more than once.

These findings are vastly different from prior studies which defined diagnosis resistance more narrowly and reported that it was rare in primary care settings. Indeed, I have found that patients resist diagnoses slightly more often than they do not. This suggests that patients do have lingering concerns about their condition and its assessment, and that both participants may be facing the interactional and social challenges of diagnosis resistance more often than previously recognized. It also challenges the notion that patients are “surrendering their private judgment” (Starr 1982) and accepting physicians’ diagnostic assessments “on authority” (Parsons 1951).

In the next section, however, I show that although patients are resisting physicians’

assessments more often than previously thought, they are doing so carefully, relying primarily on actions which substantively fall in their own domain of lifeworld expertise and interactionally place the least constraints on physicians to respond. Patients also do extensive work to mitigate the inappropriateness of their resistant turns and the implicit challenge they may present to the physician's authority. These findings suggest that patients are orienting to their resistance as potentially problematic, even if the purpose of that resistance was not to disagree with the physician's assessment or challenge their authority *per se*.

2.4.2 Diagnosis Resistance – Domain, Format & Design

The action types in the data that fit my operationalization of diagnosis resistance include (a) inquiring about a diagnostic test, (b) questioning exam or test findings, (c) inquiring about a candidate diagnosis, (d) requesting a diagnostic assessment, and (e) describing symptoms or other aspects of the patient's illness experience. In the following analysis I examine these actions in terms of their substantive epistemic *domain*, their *format*, and their *design*.

Resistant actions are split into three categories shaped by *domain* and *format*: those which substantively fall in the domain of clinical knowledge and are formatted as questions (a-d); those which fall in the lifeworld domain and are formatted as assertions (e); and those which I argue cross domains by framing something substantively in one domain, e.g., a symptom description, in the format of the other domain, e.g., a question. Patients have different rights to engage in these actions, and place different constraints on physicians to respond, as summarized in Figure 1.

Figure 1: Threats to asymmetries by resistant action type

	Interactional			Epistemic
	Structural	Local – Initiative	Local – Constraint	
Clinical Domain (Questions)	●	●	●	●
Lifeworld Domain (Assertions)	●	●		

As new actions initiated while the physician is engaged in counseling, actions in both categories threaten the initiative aspect of local interactional asymmetries. This is reflected in the *design* of resistant actions, as patients do work across resistance types to mitigate the hearable inappropriateness of their turns. And because they all in some way renew the relevance of information-gathering, all resistance types also threaten structural interactional asymmetries.

However, as questions, only actions in the clinical domain threaten the constraint aspect of local interactional asymmetries. Actions in the clinical domain are also the only ones to directly threaten epistemic asymmetries. As I will show, this is reflected in the *design* of resistant actions, such that patients do extra work only with actions in the clinical domain to mitigate these threats. In contrast, as assertions, actions in the lifeworld domain do not as strongly constrain physicians to respond, and they only threaten the physician's epistemic authority indirectly, via the move they make to an activity context where the physician's assessment may still be shaped.

I suggest that there is a cline here in the extent to which patients' actions threaten interactional and epistemic asymmetries, such that actions in the clinical domain most directly threaten epistemic asymmetries and place the greatest constraint on the physician to respond; actions in the lifeworld domain only indirectly threaten epistemic asymmetries and place the least constraint on the physician to respond; and actions crossing domains lie somewhere in the middle. In the following analyses, I provide examples of the various ways patients resist diagnoses and provide analytical evidence in support of this cline. I find that, overall, patients tend to resist diagnostic assessments primarily through the least overt types of resistance. This finding, combined with the turn designs patients use to mitigate how strongly they can be heard to threaten interactional and epistemic asymmetries, suggest that although patients are indeed resisting diagnoses far more often than previously supposed, they are nonetheless doing so in ways that orient to their normative lack of rights to do so.

2.4.2.1 Actions in the Clinical Domain

Actions that resist a diagnostic assessment vis-à-vis the domain of clinical knowledge include inquiring about a diagnostic test, questioning exam or test findings, inquiring about a candidate diagnosis, and requesting a diagnostic assessment. These actions renew the relevance of diagnostic inquiry by explicitly asking the physician to revisit the preceding inquiry, engage in further investigation, or consider something entirely new.

a. Inquiring About a Test

The first two types of resistance in the clinical domain – inquiring about tests and questioning exam or test findings – are perhaps the most overt (not including outright challenges to a diagnostic assessment as illustrated in Extract 1, which only occurs once in the data, in the PCT dataset) and, correspondingly, the least frequent.

The first extract illustrates a patient inquiring about a diagnostic test. Although patients occasionally request tests, almost all cases involve an inquiry rather than an overt request. In this visit the patient has presented with arm pain and finger numbness. During information-gathering earlier in the visit, the patient suggested she might have “a little blockage” in her arm, and inquired about an ultrasound “or something” (not shown). The physician has moved into counseling with “The cause of your pain is pretty classic for cervical radiculopathy, which is a fancy name for a pinched nerve” (not shown). He then explains how a pinched nerve in the neck can lead to arm pain. As part of this, in lines 1-5 of the excerpt, he offers to show the patient a picture, and searches for one online. In the midst of this activity, the patient asks “so is there x-rays that can give you a look at it” in line 6.

(7) AMH 01-12 Counseling

1 DOC: So:- (.) °>Lemme show< you a picture.° ((typing))
2 (3.0) ((typing))
3 DOC: °Radiculopathy:,° ((typing))
4 (1.5) ((typing))
5 DOC: °Pictur:e,° ((typing))
6 PAT: -> So is there x-rays that can give you a look- at it,
7 DOC: .pt .hh So- x-ra:ys, ar:e are not=u:m (0.5) are
8 not that helpful?
9 (0.2)
10 DOC: because they: (1.0) basically: um: (0.5) .t (0.5)
11 e- u:h they- they don't diagnose thee=uh condition
12 it's actually a clinical diagnosis,

By asking about an x-ray the patient reveals her own diagnostic reasoning and enters the physician's domain of expertise. That the physician has not mentioned an x-ray himself suggests he has made an assessment that no further diagnostic inquiry is necessary. By suggesting otherwise, the patient's question renews the relevance of further inquiry. Thus although the patient does not overtly disagree with or reject the physician's diagnostic assessment, she does resist accepting or going along with it as is. In lines 10-12, the physician responds that x-rays are not helpful because the diagnosis is "actually a clinical diagnosis," i.e., one that is normally made based on history-taking and physical examination alone. With this response, the physician explains that the inquiry he's already done is sufficient.

b. Questioning the Evidence

The next two extracts illustrate patients questioning the evidence upon which a diagnostic assessment is based. In the first extract the patient questions the findings from a diagnostic test, and in the second the patient questions findings from the physical exam.

In Extract 8 the patient has presented with upper respiratory symptoms including congestion and throat pain. He has mentioned that his co-workers have come down with various illnesses including strep throat, sinus infections and ear infections. The physician's initial assessment is that "more than anything it looks like an upper respiratory tract infection" (not shown). But because of the patient's exposure he recommends a rapid strep test (RST), which can be done on-site while the

patient waits. Positive RST results are an indication for antibiotics. If a test is negative but a physician still suspects strep throat, the physician may order a throat culture, which takes multiple days to process but may detect more forms of strep than the RST.

After doing the RST, the physician delivers a diagnosis with “it was positive for strep” in line 1. This diagnosis contradicts the initial one, and is delivered in an evidentialized format, treating the diagnosis as an accountable issue (Peräkylä 1998). The patient responds “oh lucky me,” which is delivered as intentionally ironic, and the physician affiliates with the irony with “yeah it’s your lucky day” in line 4. The patient takes the floor again by repeating “oh lucky” in line 5. Just as the physician is about to move on (“so uh” in line 6), the patient adds another unit of talk, designed as an expansion of this sequence with its “and” preface, questioning the test’s accuracy (“and those are pretty accurate when they test positive right”) in lines 7-8.

(8) AMH 03-02 Diagnosis into counseling

```

1  DOC:    Alri::ght so [it was positive for stre[:p.    [Yea:h
2  PAT:    [( )                                     [O::h lu[cky
3          [me::.
4  DOC:    [((laughs)) Yeah it's your lucky da:[y.
5  PAT:    [O:h lucky:.
6  DOC:    So:=[uh:
7  PAT: -> [And those are pretty accurate when the:y test
8          -> positive right,=I know [the negatives ar:-
9  DOC:    [Yea:h if the- yea:h if
10         tha:t [that rapid one comes back positive (you're)
11 PAT:    [Yeah.
12 DOC:    pretty su[re that it's po:sitive.
13 PAT:    [Oh lucky me:.

```

The patient rushes through to the beginning of an account for this question in line 8 (“I know the negatives are...”), which is likely a reference to the fact that negative RSTs are often treated as uncertain. This displays accountability for questioning clinical findings, and thus orients to the turn as an incursion into the physician’s epistemic domain. But although the question is formatted to prefer a *yes* response (Heritage 2010; Heritage & Raymond 2021), by asking it in the first place, the patient introduces the possibility that the test is *not* accurate, calling the physician’s

diagnostic assessment into question. After the physician confirms the relative accuracy of the test in lines 9 through 12, the patient recycles his original response (“oh lucky me” in line 13), orienting to the physician’s turn as a reassertion of the diagnosis and thus a closure of this resistance sequence.

In Extract 9 a patient questions findings from the physical exam. This patient has presented a “symptoms only” (Stivers 2002a) complaint of ear pain, neither suggesting a candidate diagnoses nor requesting a specific course of action like a prescription or test. The physician moved into counseling with “what I’m gonna do is go ahead and give you a couple things... one, because you look like you have an infection in the canal, give you some ear drops that you can use” (not shown). She has also recommended oral antibiotics, Sudafed and a nasal spray. After some intervening talk about these treatments, she turns to the patient’s chart in line 1, and after two seconds of silence, the patient asks “so the ear drum looks okay, or...” in line 2.

(9) PCT 10-05 Counseling

1 (2.2) ((DOC looking in PAT’s chart))
2 PAT: -> So the ear drum:, (0.2) looks: (.) oka:y, o[r
3 DOC: [Ear drum looks
4 okay but the canal is really all [like full of goop
5 PAT: [Really,
6 DOC: and stu[ff like (0.2) it looks infected.
7 PAT: [.sss
8 PAT: Okay.

Questions like this, which reveal an underlying concern that there *is* something wrong with the examined body part, are similar to candidate diagnoses, which will be covered in the next section. Relevantly, though, patients who ask such questions choose to topicalize the evidence *per se*. Doing so engages with the empirical realm only, rather than diagnostic assessment (see Gill 1998), and leaves it to the physician to infer and/or address the link. As in the previous extract, this question is designed to prefer a response that indeed confirms the physician’s assessment. But by raising the question in the first place, the patient suggests a possibility that the ear drum does *not* look okay (further oriented to by the turn-final “or”; Lindström 1997; Drake 2015). She thus invites

reconsideration of the fit between the physician's assessment and the patient's experience, implicitly challenging the physician's authority to have assessed the patient's problem and moved on – without mentioning the ear drum – in the first place. In response the physician confirms, claiming epistemic authority through a partial repeat (Heritage & Raymond 2005; Heritage 2012), that the “ear drum looks okay” in lines 3–4. She then reasserts the diagnosis in line 6 using an evidentialized format (“it looks infected”), orienting to the diagnosis as an accountable issue and to the patient's turn as challenge to it. The patient explicitly accepts this diagnosis with “okay” in line 8.

c. Inquiring About a Candidate Diagnoses

The next resistant action type in the domain of clinical knowledge is inquiring about a candidate diagnosis. In some cases, as in Extract 10, the patient's candidate diagnosis and the physician's stated diagnosis are mutually exclusive. In other cases, however, the diagnosis and the candidate diagnosis are not mutually exclusive, or the candidate diagnosis is presented in a context where the physician has not diagnosed the problem at all, and so there is nothing for the candidate diagnosis to disagree *with*. Thus, while in some cases candidate diagnoses directly resist the physician's diagnosis, in others they merely resist the physician's decision not to *rule out* the candidate diagnosis the patient is inquiring about.

In this visit the patient has presented with chest pain when taking deep breaths. During information-gathering she emphasized the pain and duration of her problem and inquired about a chest x-ray; the physician deferred an assessment of the relevance of an x-ray with “we'll take a listen” (not shown). After the exam, he delivered the diagnostic utterance: “you do have more than likely a muscle strain along your ribs there,” adding that “the lungs sound great... you're moving air really well” (not shown). During subsequent treatment talk the patient muses about how long it will take her pain to get better, and in lines 1-3 the physician finishes explaining that it takes so long

because the patient's cough re-injures her ribs. In lines 4-5, the patient asks, "is there any chance I could've torn a muscle?"

(10) AMH 03-11 Counseling

1 DOC: A:nd that (.) injures 'em again:so even
2 though they're trying to heal up you cough and
3 (ok[ay) now it's a little more (in[jured).
4 PAT: -> [Mm hm, [Is there
5 -> any:- chance that I could've torn a muscle?
6 DOC: U:[m,
7 PAT: [Or not really.=These are intercostals.=
8 DOC: =Yea:h yeah usually- I mean: is it p- ih:s it's
9 possibl:e. Likelihood is very very [low,
10 PAT: [Low.

As in Extract 8, the patient accounts for her incursion into the physician's epistemic territory by showing some knowledge of the anatomy of the area ("these are intercostals" in line 7).

Nonetheless, by suggesting a diagnosis the physician has neither named nor ruled out, the patient resists accepting the physician's diagnosis pending explicit consideration of this alternative, implicitly challenging the physician's primary epistemic rights to diagnose. Moreover, by creating a slot in which the physician must, at minimum, rule out the candidate diagnosis and/or reassert the original one, the patient threatens structural interactional asymmetries by returning to an activity context preceding assessment. In lines 8-9 the physician acknowledges the possibility of a torn muscle but asserts that the likelihood is "very very low." In a context where the candidate diagnosis (a tear) is a more severe version of the stated diagnosis (a strain), ruling out the candidate constitutes reassertion of the original. The patient acknowledges this by co-completing his utterance with "low" in line 10.

d. Requests for Diagnosis

The final type of diagnosis resistance in the domain of clinical knowledge is requesting a diagnosis. Whereas candidate diagnoses request comment on some previously unmentioned potential cause of the patient's condition, requests for diagnoses seek diagnostic comment more generally. In some cases, as in the first extract below, patients request a diagnosis in the absence of

one, resisting the physician's decision not to diagnose, or at least not to name a diagnosis. In the second extract, in contrast, the patient requests a diagnosis in a context where the physician *has* named a diagnosis, but it does not address all aspects of the patient's complaint.

In Extract 11 the patient, who is diabetic, has presented with a recurring, painful growth on her foot. In the course of describing this problem, she has mentioned multiple concerns underlying her complaint: difficulties getting the problem addressed by another physician; the potential need for a disability placard because of difficulties walking; and fear of ending up like a diabetic aunt, who had a leg amputated. As I discuss in Chapter 4, presentations like this can make it difficult for physicians to determine the patient's primary concern(s), and therefore how to structure counseling. In this case, the physician takes up the patient's fear of amputation when he moves into counseling with a recommendation for stronger control of her blood sugar to prevent the "complications of diabetes" (lines 4-12). This recommendation links the patient's foot problem to her diabetes both sequentially and in an embodied way, as the physician looks at the patient's foot during the 4-second silence in line 10 before suggesting a "diabetes doctor." He does not, however, diagnose the problem explicitly.

(11) AMH 01-09 Diagnostic assessment into counseling

1 PAT: And then sometimes it hurts when you walk.
2 DOC: °Mm hm°
3 PAT: Y'kno:w,
4 DOC: W'll the key: (0.2) way to preven:t (1.0) thee:
5 (0.8) complications, of diabetes?
6 PAT: Mm hm:,
7 (1.0)
8 DOC: is: (0.5) stronger control: of the blood sugar,
9 PAT: Mm hm:,
10 (4.0) ((DOC patting own thigh, looking at PAT's foot))
11 DOC: .hh You know- We have a goo:d young: new: diabetes
12 doctor:.
((lines omitted, discussing name and location of doc))
13 DOC: I: would recommend (.) gettin' ya in to see him:.
14 (0.8)
15 DOC: Be:cau::se (0.8) I think he's gonna kinda take
16 some ownership.
17 (.)
18 DOC: An:d really push you.

19 (0.2)
 20 DOC: To get your diabetes better,=If you get your
 21 diabetes better: (1.2) you're gonna be:: in a
 22 better- your feet are gonna feel better:,
 23 PAT: Mm hm.
 24 (0.2)
 25 DOC: Your[:
 26 PAT: -> [So you think it's because of the
 27 -> diabetes? my foot is like this?
 28 (0.2)
 29 DOC: .t Well the growth I don't know about #that#.
 30 (0.5)
 31 PAT: Mm[:.
 32 DOC: [Bu::t the other pains and do- the way to
 33 prevent (0.5) complications: (0.8) like (.
 34 am[putation,
 35 PAT: [Mm hm.
 36 (0.5)
 37 DOC: is good control of blood sugar.
 38 PAT: Okay.

The patient does not respond to the physician's recommendation in line 13, and the physician pursues agreement by naming some reasons the doctor will be helpful: he'll take "ownership" (lines 15-16) and push her to improve her diabetes (lines 18 and 20). In lines 20-22, he begins listing benefits she will experience from improving her diabetes. The first item in the list is that her "feet are gonna feel better" (line 22). But as he moves to the second item in the list, the patient asks, "so you think it's because of the diabetes my foot is like this?" in 26. Although this question presents a diagnosis for confirmation, it is not like mentioning a candidate diagnosis, because the patient is observably drawing an inference from the physician's talk, rather than presenting her own theory. A simpler version of requesting a diagnosis might be "so what is it?" although such questions are rare.

This question requests a diagnosis in a context where the physician has not provided one. It could be argued, however, that a diagnosis was implicit in the recommendation because the physician himself linked the two. But in response to the patient's question, he admits "well the growth I don't know about that" in line 29. This reveals that he had not in fact diagnosed the problem, but rather determined that the most relevant course of action was to address the patient's

fear of diabetes complications (see also Heritage & McArthur 2019). Nonetheless, he allowed his recommendation for blood sugar control to be hearable to the patient as responsive to her foot complaint. This practice actually occurs with some regularity, where a physician glosses over diagnostic uncertainty by focusing on something else during counseling, and it's only when a patient requests a diagnosis that the move is revealed and the physician's assessment – that diagnosis was not the relevant clinical course of action – becomes clear. Requests for diagnosis in this context present a threat to epistemic asymmetries by resisting this assessment.

When patients request a diagnosis in the absence of one, they renew the relevance of diagnostic investigation. When physicians acknowledge diagnostic uncertainty, they make this relevance even stronger. In this case, the physician merely returns to his original course of action by adding that complications in general can be prevented by good control of blood sugar (lines 32-37). By doing so, he reasserts his original assessment that diagnosis is not relevant and maintains forward progression through counseling.

In Extract 12, in contrast, the patient requests a diagnosis in a context where the physician *has* named one, but it does not address all aspects of the patient's complaint. This patient has presented with an elbow 'snap' followed by pain and swelling. This problem presentation is analyzed in more depth in Chapter 4. In lines 1-7 the physician diagnoses the problem as olecranon bursitis, a swelling of a fluid-filled sac in the elbow, and a skin infection. This diagnosis addresses the pain and swelling in the elbow, but not the snap. After responding to the diagnosis with "I see" in line 8, the patient asks, "and the snap?" in line 11.

(12) AMH 02-03 Diagnosis into counseling

1 DOC: It's probably a superficial thing, (.) u::h you
2 probably got a wh- you know olecrenon: uh- bursitis
3 from fluid in the joint there, .hh and then you
4 probably got a little superficial skin infection or
5 somethin' I don't know. .h 'Cause if you had a joint
6 infection: (.) I would expect it to: (.) have
7 been a lo:t more serious.

8 PAT: I see.
 9 DOC: Yeah.
 10 (0.5)
 11 PAT: -> And the sna:p?
 12 (0.2)
 13 DOC: .h Well the- who- who knows what the sn(h)a(h)p was.

This question resists the physician’s assessment that diagnosis of the pain and swelling is relevant, but not the snap. By asking the physician for a diagnosis he has determined is not relevant, the patient renews the relevance of the diagnostic process that led to his diagnosis – and what *not* to diagnose – in the first place. The physician’s response in line 13 indeed displays his interpretation of the patient’s action along these lines. By saying “who knows what the snap was” he reveals not only that he did not come up with a diagnosis of the snap, but also that his assessment of the patient’s problem included a decision that a diagnosis of the snap was irrelevant. This is further evidence that requests for diagnosis indeed resist the physician’s assessment-so-far by renewing the relevance of diagnostic inquiry.

e. Distributions

Table 1 shows the distribution of resistance in the physician’s domain of clinical expertise.

Table 1
 Distribution of diagnosis resistance in clinical domain

Resistant action type	<i>Frequency</i>	<i>Percent</i>
Requesting diagnosis	15	48%
Inquiring about a candidate diagnosis	8	26%
Inquiring about a test	5	16%
Questioning findings	3	10%
Total	31	100%

As actions generally directed toward the physician’s domain of expertise rather than the patient’s, these resistant actions present, on the whole, a more overt challenge to the physician’s epistemic authority than those in the patient’s lifeworld domain. This is reflected in the fact that

these numbers are fairly small relative to the total amount of diagnosis resistance in the data (n=183). This trend is also reflected in the distribution of action types within this category: the actions that are produced the least – questioning findings (n=3) and inquiring about a test (n=5) – may indeed be heard to most strongly challenge a physician’s expertise in diagnosing a condition. Questioning a candidate diagnosis (n=8) may present slightly less of a challenge, as the patient may accountably be heard as merely expressing a concern; and requesting a diagnosis, which represents nearly half of all actions in this domain (n=15), may be even slightly less so, as the patient’s desire for a diagnosis moves even more into the arena of patient expectations for a diagnosis, as opposed to the patient engaging in diagnostic reasoning *per se*.

Patients also design their resistant turns in this domain in ways that work to mitigate (and thus orient to) the increased threat they present to epistemic and local interactional asymmetries. For instance, patients tend to design their questions to grammatically prefer a response that confirms the physician’s original assessment – e.g., “those are pretty accurate when they test positive, right” (Extract 8), “so the ear drum looks okay” (Extract 9), “is there any chance I could’ve torn a muscle... or not really” (Extract 10) – which Peräkylä (2002) and Stivers (2007) have also observed. Patients also sometimes display relevant clinical knowledge when directing questions toward the clinical domain – e.g., “I know the negatives are...” (Extract 8), “these are intercostals” (Extract 10) – which somewhat accounts for the incursion into the physician’s domain. That patients engage in resistance in the clinical domain so much less frequently than other types of resistance, and that they do work to mitigate the extent to which they can be heard to threaten the physician’s epistemic primacy in this domain, are evidence of a general patient orientation toward these types of resistance as more overtly threatening to the physician’s epistemic authority to diagnose, and more interactionally problematic.

2.4.2.2 Actions in the Lifeworld Domain

Patients resist a physician's diagnostic assessment in the domain of lifeworld knowledge – or, as Mishler (1984) puts it, in the “voice of the lifeworld” – by volunteering descriptions of symptoms or other aspects of their illness experience. Unlike actions in the clinical domain, these informings do not explicitly ask the physician to revisit or engage in new diagnostic inquiry. However, information about the patient's illness experience is normatively given to a physician during the information-gathering phases preceding counseling (see Heath 1992; Peräkylä 2002; Heritage & Robinson 2006a,b; Gill, Pomerantz & Denvir 2009; Ijäs-Kallio, Ruusuvuori & Peräkylä 2010). As Heath (1992), Peräkylä (2002), and Ijäs-Kallio et al. (2010) have observed, they may thus be hearably resistant when produced in direct response to a diagnosis. I argue that doing so even at great distances from a diagnosis, or during counseling phases where no “official” diagnosis was delivered in the first place, challenges the physician's diagnostic assessment. This is because doing so renews the relevance of diagnostic inquiry, making a move to an activity context where that assessment may still be shaped.

Descriptions of the patient's illness experience include descriptions of symptoms in the here-and-now (“right now it's like tingling”), ongoing symptoms (“sometimes my hands and feet fall asleep easier than before”), the history of the problem (“over the last year I haven't had any flare-ups, but now it's all the time”), life circumstances or events related to the problem (“I wore some new shoes to the gym”) or medical history related to it (“I get inflammation in weird places”), past experience with related problems (“it's funny because both times I was really really sick when I had strep”), and lifeworld difficulties due to the problem (“it's hard for me to work”). These descriptions vary in the degree to which the patient can be heard to have an underlying concern related to the diagnostic assessment. Indeed, in some cases, for example descriptions of lifeworld difficulties, it may not be clear *what* the patient's project or underlying concern is, e.g., diagnosis, treatment, or

merely the legitimacy of the visit in the first place (Heritage & Robinson 2006a). Especially when they are designedly tied to some local activity or warrant for engaging in this talk (see below), some resistant actions in this domain go so far off-record that they are not accountably hearable *as* resistance to the assessment *per se*. Nonetheless, all informings threaten progressivity, make relevant some kind of physician uptake and, most importantly, re-invoke information-gathering activities.

Patients have epistemic rights to know about and discuss issues in their own domain of lifeworld expertise, and so we do not see patients doing work to account for or mitigate their claims as they did with actions in the clinical domain. But informings during counseling are nonetheless problematic in that they renew the relevance of information-gathering, making a move to an activity context where the physician's assessment may still be shaped. Patients do work to mitigate these threats by, in many cases, designing their informings to appear locally warranted. I illustrate three main warrants patients draw on: the physician's own just-prior move into the patient's domain; inner sensations that have ostensibly just now occurred; and talk about treatment. Even in cases where there is no local warrant, I show that patients use turn prefaces and other design features to mitigate the hearable inappositeness of their informings.

As has been shown in other contexts, designing volunteered information as warranted is a resource for accountably engaging in actions that might otherwise be problematic, such as providing more information than the physician requested (Stivers & Heritage 2001), volunteering pain information during a physical exam when the physician hasn't asked for it (McArthur 2018) and, as I argue here, resisting a diagnostic assessment through new or repeated descriptions of the patient's illness experience. Informings that are not designedly warranted risk being heard as done for some other cause, like pushing back against the physician's diagnostic assessment. When patients work to design an informing as locally warranted, they provide an accountable motivation for providing that information out-of-activity, mitigating disruption to epistemic and interactional asymmetries.

a. Physician Talk in the Patient's Domain

The following extracts illustrate the three primary ways a physician's talk may move into the patient's domain during counseling, providing an accountable reason a patient may volunteer further information in that domain. These physician actions include asking additional history-taking questions; describing the patient's symptoms or the "typical" symptoms of patients suffering from a similar condition; and expressions of empathy.

The first way physicians' talk may move into the patient's domain is through further history-taking. When physicians ask a history-taking question or engage in further examination they return to information-gathering themselves, however briefly. When a physician asks for further symptom information, the patient's response with that information is not resistant. However, patients sometimes add more, un-asked-for information either appended to their answering turn ("answering more than the question"; Stivers & Heritage 2001) or after the history-taking sequence is closed.

Extract 13 illustrates the latter.

In this visit the patient has presented with ankle pain and swelling that has been going on for a week. He mentioned to the nurse that "as far as I'm concerned I didn't do anything to it" (not shown). Although he has not mentioned this to the physician on-camera, he likely did during a phone call they had the evening before. The physician shifts into counseling with a recommendation that "because of the swelling I am gonna go ahead and x-ray it just to make sure there's no bony deformity" (not shown). After recommending over-the-counter treatment, she adds in line 1 that "it looks like a sprain." After acknowledging uncertainty about the etiology in lines 4-8, she asks in lines 8-14 if the patient can remember anything he could have done to strain it. The patient responds in the negative in line 15, repeating "not at all" in lines 17 and 19. The physician takes this up with a sequence-closing "okay" (Schegloff 2007), also repeated, in lines 18 and 20. She then turns away

from the patient to reach for a form in a holder on the wall behind her and adds “sometimes that’s how it happens” in line 22.

(13) PCT 14-04 Diagnosis into counseling

1 DOC: .h u:m it ^looks like a st- a sprain:.
2 (.)
3 PAT: [(Really,)
4 DOC: [Or strain.>You know what I mean, I don’t< kno:w-
5 PAT: [°(Oh)°
6 DOC: [‘cause it’s weird ‘cause we can’t figure out a
7 PAT: [((shakes head)) ()
8 DOC: [history to go with it. .h **A- even after- last night**
9 **after we talked on the phone did you (.) .h come up**
10 **with any:thing:**
11 (1.5)
12 DOC: **e-that you could’ve do::ne, to strain: i::t, or:**
13 (0.5) ((PAT shaking head))
14 DOC: **Could you remember anything:,**
15 PAT: [Hm mm.
16 DOC: [No,
17 PAT: Not at a:ll.
18 DOC: O[kay,
19 PAT: [Not at all.
20 DOC: ^Okay,
21 (0.5) ((DOC turns to reach for form in holder on wall))
22 DOC: So::metimes that’s how it ^happens.
23 (0.5)
24 PAT: -> °I don’t know ho:w I- (.) really don’t know how () .°
25 (3.0) ((DOC ruffling papers, facing away from PAT))
26 PAT: -> °I haven’t played any sports in a lo:ng time.°
27 (0.5) ((DOC still facing away from PAT))
28 PAT: °So.°
29 (0.5)
30 DOC: Okay and I have your cholesterol results.

After this bid for sequence and topic closure, the patient adds in line 24 that he doesn’t know how he hurt his ankle, and that he hasn’t “played any sports in a long time” in line 26. On its face, the patient’s negative responses to the physician’s question in lines 15, 17 and 19 cast doubt on the diagnosis of a sprain, but the physician was the one who opened the opportunity space to do so in the first place. Her question, however, was about whether the patient could *remember* anything, which, even if answered negatively, preserves the possibility that he did sprain it. By adding the additional, un-asked for detail that he has not played sports in a long time, the patient casts further doubt on the diagnosis by showing that he hasn’t had an opportunity to sprain his ankle. Because

this is delivered as the physician is observably moving on to something else, it threatens structural interactional asymmetries by renewing the relevance of further investigation. However, because it is delivered on the heels of the physician's own return to information-gathering, it is designed as somewhat locally warranted by the physician's own move to re-invite the patient's perspective.

The second way physicians' talk may move into the patient's domain is by describing symptoms related to the patient's condition, for example when explaining a diagnosis, explaining how a diagnosis differs from some other condition, accounting for further testing pursuing some diagnosis, and so on. Physician symptom descriptions almost never designedly pursue patient response. However, in some cases patients use this interactional space to contrast or disconfirm the physician's understanding of the problem by describing some aspect of their own illness experience. Extract 14 illustrates this.

This extract revisits the same patient as in Extract 7. She has presented with arm pain and finger numbness and has mentioned a candidate diagnosis of "a little blockage" in the arm. In lines 1-3 of this excerpt the physician is explaining how his diagnosis of a pinched nerve in the neck can cause pain to shoot "down the arm." In lines 4-9, the patient contradicts the physician's description of her pain as shooting and describes it instead as "centrally located."

(14) AMH 01-12 Counseling

```
1  DOC:      And that's why certain positions (0.5) cause it to
2            really pinch.=and then you get that pain that shoots
3            down the a[rm,
4  PAT: ->           [It seems like the pain is just- ce[ntrally
5  DOC:                                     [Yeah.
6  PAT: -> located though.=
7  DOC:      =^Yeah.= ((nodding))
8  PAT: -> =I don't feel it shootin:==just see->centrally<
9            -> located.
10 DOC:      ^Yeah.= ((nodding))
```

This symptom description observably contrasts with the physician's characterization of the patient's problem, because pain that shoots from the neck down the arm is mutually exclusive from pain that is centrally located near the elbow. Moreover, the patient designs her symptom description

as a contrast with the physician's characterization, adding *just* in line 4 and *though* in line 6, and replacing *shooting* with *centrally located* in lines 8-9: "I don't feel it shootin' just... centrally located."

Unlike plain symptom descriptions, which call the physician's assessment into question only by virtue of renewing the relevance of information-gathering, contradictory symptom descriptions like this one correct the physician's characterization of the problem, introducing the possibility that the physician misunderstands the problem itself. But like all symptom descriptions, physicians can ignore the potential clinical implication of what the patient is saying. Here, as I will show in greater detail in the next chapter, the physician takes up the patient's talk with "yeah" in lines 7 and 10. Produced with nods and a higher pitch onset relative to surrounding talk, these acknowledgments treat the patient's symptom description as expectable or in line with his own.

The final way patients tie to physicians' talk that moves into their own epistemic domain is by telling their own side in response to some expression of empathy or understanding of the patient's perspective. Extract 15 illustrates this.

The patient in this visit has recently recovered from a shingles infection which caused painful lesions on her forehead and into her hairline, and problems with her eyes. She was treated by another physician with an anti-viral medication and a medication specifically for shingles-related pain, and the pain is now gone. This is a return visit because she is now experiencing intense itching in the areas where she had the pain. It emerges throughout the visit that she believes she is having a recurrence of shingles, which is underpinned by her understanding that "itching is a form of pain" (not shown). The physician's diagnostic assessment, however, is that she has recovered from the shingles, and is now having some "post-inflammatory" itching (not shown) and that the patient just needs some kind of antihistamine to treat the itching.

Much later, during talk about treatment, the physician requests confirmation that the patient completed her anti-viral treatment course (not shown). Following that sequence the patient asks, "so

I don't need any more of that?" in line 1, somewhat obliquely renewing her concern that the shingles virus is not gone. The physician disconfirms repeatedly with "I don't think so," "No I don't think you do" and "I think we're good" in lines 2-3, before repeating that he thinks "we just need to treat the itching at this point" in lines 3-5. After typing on the computer during the 18-second silence in line 6, he adds "I'm just so happy that that pain's gone" in line 7.

(15) AMH 02-08 Counseling

1 PAT: So I don't need any more of that?
2 DOC: I don't think so. °No. I don't think° you do. I
3 think we're good. [I think we just need to
4 PAT: [°^Okay°
5 DOC: treat the itching at this point.
6 (18.0) ((DOC on computer))
7 **DOC: I'm just so happy that that pain's gone.**
8 °(Boy.)°
9 PAT: [Oh yeah.
10 **DOC: [That's a relief I'll tell ya.**
11 PAT: -> Well I'm gla:d.<'Cause- I mean I was feeling
12 -> like the itching is the same thing only (1.0)
13 -> a different form.=so that [it's (.)] [not a
14 DOC: [I- [I-
15 -> [good si:gn.
16 DOC: [I don't think it is?<Now (.) you kno:w (1.0)
17 it is true that sometimes (.) it is true: (0.5)
18 that when you first have something goin' on with
19 the skin it may start as an itch and later become
20 painful.=but I don't think that's what's
21 happening here.
22 PAT: No: it's not becoming painful.
23 DOC: °Yea:h.°

This comment continues to display the physician's stance that the problem is resolved because the pain is gone. However, by characterizing his own emotional state ("so happy") as it relates to the patient's suffering ("that the pain's gone"), combined with the interjection "boy" in line 8, the physician delivers this as an expression of empathy for the patient's personal experience of her illness. It further enters the patient's domain by taking a stance on the patient's experience as positive, despite the itching and the patient's fear of a returned virus.

In response the patient says "oh yeah," agreeing in a way that is upgraded and claims prior and thus primary access to this knowledge (Heritage 2002). In overlap the physician adds "that's a

relief I'll tell ya" in line 10. By casting the disappearance of pain as a "relief," the physician further casts it as good news. The patient responds with "well I'm glad" in line 11, affiliating with the physician's stance. The turn-initial "well" here indexes the turn as a pivot from the physician's perspective to a telling of the patient's own side (Heritage 2015). From here she adds "because" and "I mean," both of which cast her impending expansion as unpacking *why* she's glad. She then re-asserts her prior understanding that the itching is "the same thing" as the pain "only a different form so that it's not a good sign" in lines 11-15. By formatting this in the past tense (i.e., "I was feeling"), the patient implicitly orients to having accepted the physician's assessment. Nonetheless by raising this again, the patient renews her prior resistance. The physician indeed orients to this by again ruling out that the itching is a sign of shingles with "I don't think it is" in line 16, followed by acknowledgement that itching *can* sometimes turn into pain (lines 16-20) before reasserting that this is not "what's happening here" (lines 20-21).

In this case, the physician moved into the patient's domain when he expressed empathy for the patient's illness experience, and the patient tied to this as a local warrant for revisiting her earlier belief that her itching was "not a good sign" and meant that the shingles had returned.

b. Opportunistic Revelations

In the absence of physician talk that moves into the patient's domain, patients may make observable their own local warrant for volunteering symptom information – a sudden internal sensation. Heath (2002) has referred to these as "opportunistic revelations," and Byrne and Long (1976) have called them a "by the way syndrome," through which patients seem to experience and then mention some symptom when they do not have the floor to discuss such things, often toward the end of the visit, i.e., during counseling or closing activities. These informings "exploit" the patient's ostensible experience of an internal feeling in an attempt to "encourage the doctor to adopt

an ‘investigative or diagnostic’ stance” toward their symptoms (Heath 2002:603-4). In these cases, it is the patient’s internal experience that warrants volunteering symptom information during counseling. Extract 16 illustrates this practice.

In this visit the patient has presented with pain after twisting his knee while playing basketball. The other symptoms he has described are a “pop” in the knee, inability to straighten the leg, and a “sensation of rushing blood” (not shown). After history-taking and a physical exam, the physician moved to counseling with “the fact that you’re not able to bend it well and straighten it out well makes me think that it’s probably a cartilage tear, and when you turned, it really caught the medial aspect of what’s called your meniscus” (not shown). He added that the “good news” is that it might heal on its own. He then instructed the patient to re-demonstrate how far he can straighten his leg – revisiting the patient’s and his own earlier judgment that he cannot straighten it well – before moderating this good news by highlighting the patient’s “lack of function” in line 1. This characterization is then cast as grounds for some forthcoming course of action with “so... what I would say we should do is” in line 2. But before he completes this utterance, the patient, who is still holding out his leg, describes new symptoms of tightness, pain and “something like kind of rubbing” in lines 3-11.

(16) AMH 02-07 Counseling

1 DOC: It's difficult because of your lack of function
2 so .hhh what I would say we should do is (0.8)
3 PAT: -> Like when I straighten it, like right no:w (0.5)
4 -> it (was) just (0.5) this feels- (.) there's like
5 -> a tightness here?=
6 DOC: =Yeah.=
7 PAT: -> =And there's a pain: here.
8 DOC: Yeah.
9 PAT: -> Right in- right in: and like it kind of feels
10 -> like (.) you can feel like something like kind of
11 -> rubbing in here. (s[o])
12 DOC: [Ri:ght.
13 (0.5)
14 DOC: .t .hh Yeah >I mean< I think it's probably a
15 meniscal injury:, an:- um: (.) I think we should
16 do an xray? (0.5) .h um beca- and I don't think
17 the xray's gonna show anything:, but that's to

18 make sure there isn't something else going on,=
19 PAT: =Yeah (that's fair).

In these turns the patient designs his symptom description as touched off by a sudden internal experience by prefacing it with “like when I straighten it, like right now...” in line 3. By doing so, he implicitly accounts for providing symptom information *now* because he happens to be experiencing the symptoms *now*. Patients describing symptoms in this way are not accountable for doing so during counseling, and so are not hearable as intentionally calling the physician’s assessment into question. Nonetheless, all symptom descriptions inherently renew the relevance of information-gathering, rendering the physician’s assessment potentially revisable. The physician indeed orients to this by reasserting his diagnosis in lines 14-15.

In some cases, as in this one, patients’ symptoms are presented as resulting from something the physician has instructed the patient to do. In other cases, they are presented independently. Thus, unlike other local warrants, symptom descriptions that are ostensibly touched off by some experience inside the patient’s body are unique in that they can be done at any point in the interaction regardless of the physician’s prior behavior. This contrasts with the other extracts in this section, which illustrate patient informings that are designedly connected to (in design or sequential proximity), and thus warranted by, the physician’s own ongoing talk.

c. Tying to Talk About Treatment

Another way patients design their turns as locally warranted is by tying to talk about treatment, which they *do* have some rights to discuss or even negotiate during counseling (Lindström & Weatherall 2015; Stivers & Timmermans 2020). Consider Extract 17.

In this visit the patient presents with pain, swelling and limited mobility in his elbow. The physician’s diagnostic assessment is that this is likely a flare-up of gout, a form of arthritis. He adds that he *could* “put a needle in there” to “prove that it’s uric acid” (a sign of gout), but that he’s

hesitant to do so because of a prior surgery the patient had in that elbow (not shown). He concludes that “it’s not that important” to confirm gout and that they should just treat it as such. During talk about treatment the physician discusses the patient’s recent courses of steroids, which is one way to treat a gout flare-up, as well as another, longer-term medication that is meant to lower uric acid levels and prevent future flare-ups. The patient explains that he missed a week of that medication because it wasn’t ready at the pharmacy, but then adds that he doesn’t think that would have prevented this elbow problem (not shown). This begins to make explicit the patient’s concern, which was percolating earlier in the visit but not stated directly, that his elbow problem is not related to his gout. The physician counters that he thinks the medication *would* have prevented this problem, adding that the “bottom line is... again just to make sure that you know what we wanna do” in lines 1-4, attempting to close the sequence and return to his prior course of action discussing the treatments the patient should pursue.

(17) AMH 02-06 Counseling

1 DOC: Bottom line is- u:m (0.5) again just to make sure that
2 you kno:w
3 PAT: Yeah.
4 DOC: <y'kno:w >what we wanna do.< .h U:m
5 PAT: -> The thing is (I've like-) (0.2) I can't (.) wait
6 -> to get on it again because (0.5) lately over the last
7 -> I would sa:y (1.0) I haven't had any flar:es or
8 -> anything like tha:t in probably like (0.2) a year and
9 -> a half two years,
10 DOC: Oka:y,=
11 PAT: =And if anything: (0.2) before that (episode) I was
12 on it. .hh (the year) before,
13 DOC: Yeah.
14 PAT: Then I was off of it,
15 DOC: Yeah.
16 PAT: And the:n (0.8) recently: I would say the last six
17 months, .hh it's just been: this sort of like (0.8)
18 ongoing: (0.5) like dominoes:, ...

The patient responds with “the thing is... I can’t wait to get on it again,” referring to the medication to lower uric acid they were just talking about. This aligns with the physician’s return to that conversation and backs off of his resistance to taking this medication. However, he expands this

with “because” and then volunteers a somewhat complex description of his experience with flare-ups in the past few years. It’s not easy to follow what he’s saying, but the gist of it seems to be that he was taking this medication when a flare-up happened a few years ago (lines 11-12), and then he was off the medication for the last two years, during which he hasn’t had any flare-ups (lines 6-9) until the last six months or so when he’s begun to have ongoing problems with his joints (lines 16-18 and beyond the end of the extract). By describing symptom flare-ups that occurred while *on* the medication and a long stretch of being symptom-free while *off* the medication, the patient suggests that the medication is not actually treating his problem and supports his earlier claim that he doesn’t think it would have helped with his current elbow pain. Thus, despite the beginning of this turn, which commented on and aligned with prior treatment talk, this continues to push back against the physician’s suggestion that getting back on the medication would help with the elbow pain. Furthermore, because this medication is specifically for gout, the patient’s telling implicitly suggests that these symptom flare-ups may not in fact be gout. What the patient has ultimately done is built on prior treatment talk as a local warrant for volunteering this new symptom information which indeed pushes back against the diagnosis of a gout flare-up.

In the remaining extracts, patients have no local warrants for volunteering new or repeated descriptions of their illness experience.

d. Unwarranted Informings

Unlike resistant actions in the domain of clinical knowledge, informings in the lifeworld domain do not engage with clinical matters and leave patients with some amount of plausible deniability that they were resisting physician’s assessment into question in the first place. By not taking a stance toward the clinical relevance of such information, patients avoid being heard, on-record, to engage in diagnostic reasoning, or to challenge the physician’s reasoning (Gill 1998; Gill &

Maynard 2006; McArthur 2018). This is especially true in cases like those illustrated above, where patients implicitly account for their informings as motivated and warranted by the physician's own just-prior move into the patient's domain, by inner sensations that have ostensibly just now occurred, or by talk about treatment. When there is no warrant, in contrast, patients' motives for volunteering information during counseling remain opaque. By not revealing any motive, patients leave it up to the physician to infer one. Based on the local context, such utterances may risk being heard as accountably motivated by a desire to return to information-gathering, and thus to call the physician's assessment into question. As I show in the following examples, even in these cases patients use turn prefaces to mitigate the hearable inappropriateness of their informings, casting their turn as a continuation of their own just-prior symptom talk, or as an explanation or account for their initial presentation of the problem.

In Extract 18 the patient mitigates the hearable inappropriateness of volunteered informings about her problem by casting them as continuations of her own just-prior symptom talk.

In this visit the patient presents with a rash on her eyelid, although it becomes clear that her problem has already been addressed by another physician, an ophthalmologist, who diagnosed her with dermatitis and prescribed a topical steroid cream. The patient needs her prescription for the cream renewed and was asked by her primary care physician to come for an in-person visit before refilling the medication. The physician comments early on that she is "happy to fill the medication" but that she "just wanted to see how you were doing," and "the eye looks okay" (not shown). In response to this the patient describes some symptoms, and the physician muses about some potential causes of the rash, e.g., contact with her pillowcase, reasserts that "it's dermatitis," and explains that without further testing it's difficult to know what the trigger is. They then shift back to discussing the steroid medication, and the physician explains that because the skin on the eyelid is so thin and delicate, topical steroid use must be monitored. She restates her willingness to renew the

prescription but adds a recommendation for a referral to the dermatologist so that, she says “we can have some very like... more specific recommendations about that” in lines 1-5.

The patient accepts this recommendation with “okay” and “yeah” in lines 4 and 6, closing this sequence. But then in line 8, at relatively great distance from her earlier talk about her visit to the ophthalmologist, she adds “um he also said that it was on both eyes? ... but I really only notice it and feel it on this eye?” in lines 8-11.

(18) AMH 04-10 Counseling

1 DOC: U::m and that way we can have som:e very like (.)
2 PAT: [Mm hm,
3 DOC: [more specific recommendatio[ns.
4 PAT: [Ok[ay.
5 DOC: [#about that.#=
6 PAT: =Yeah.
7 (0.2)
8 PAT: .h U:m he also said that it was on both eyes?
9 DOC: Mm hm,
10 PAT: But I: really only notice i:t and feel it on
11 this [eye?
12 DOC: [Uh huh,=
13 PAT: -> =.h U:m (0.8) and the:n:- (0.2) and he wasn't sure
14 -> what exactly triggered i:t,
15 (0.8) ((DOC nodding))
16 PAT: -> u:m<but the dermatologist said \$this one's triggered
17 -> by stress,\$ [hh ((pointing at hairline))
18 DOC: [Mm hm:,
19 PAT: -> Which I'm not surpr(h)ised=hh [.hihhh u::m (0.8) bu:t
20 DOC: [Mm hm:,
21 PAT: -> yeah and I have noticed like on this one like
22 -> there's a l- a small: red do::t?= ((pointing))
23 DOC: =Mm hm:,
24 PAT: -> >I don't know if it's still there right now< but u:m
25 (.) ((DOC leaning in))
26 PAT: -> .hh on this par[::t,
27 DOC: [Mm hm, I can see tha[:t. Yea:h.
28 PAT: [Yeah.
29 (0.5) ((DOC backing away))
30 DOC: [#Yeah.#
31 PAT: -> [.pt U::m (0.2) 'n yeah but other than tha:t it
32 -> hasn't been::
33 DOC: Okay.
34 PAT: Yea:h.
35 DOC: O[kay.
36 PAT: -> [°bothering me.°
37 (0.2) ((DOC nodding))
38 DOC: #Yeah.# So: [I think let's go ahead and do tha:t,
39 PAT: [°So.°

Coming on the heels of discussion about treatment and a referral to a specialist, and long after the switch from information-gathering to counseling, this volunteered informing renews the relevance of information-gathering and diagnostic reasoning. It is also completely unwarranted by the local interactional context. But by using the locally subsequent reference term “he” (Schegloff 1996) and the modifier “also,” the patient ties this talk back to her earlier explanation of what she was told by the ophthalmologist. This is not the focal volunteered informing, although it *is* similar to the work done by some of the prefaces discussed in the next section, which tie back to talk that ostensibly occurred during information-gathering. The focus here is on the patient’s subsequent turns, which add further bits information in increments, and are built as continuations of the turn initiated here.

In line 13 the patient works to keep the floor through a latched in-breath and lengthened “um,” and adds “and then... and he wasn’t sure what exactly triggered it” in lines 13-14. This is built as a continuation of the prior turn through “and then,” which marks it as a next chronological item, and the locally subsequent reference term “he.” She then proffers a candidate trigger for her eyelid dermatitis by adding that her dermatologist said that a separate rash she has – in her hairline – is caused by stress; this is prefaced with “but,” which again ties back to the prior turn. The physician takes this up with “mm hm,” and the patient adds “which I’m not surprised” in line 18. Again tied back to the prior turn with “which,” this addition suggests but does not explicitly state that the patient has problems with stress, which might also be a trigger for her eyelid dermatitis. The physician does not pursue this, though, and again only takes this up with “mm hm” in line 20.

The patient adds yet another bit of information with “but yeah and I have noticed like on this one there’s like a l- a small red dot?” in lines 19-22, followed by bids for the physician to visually inspect her eyelid via pointing in line 22 and “I don’t know if it’s still there right now” in line 24. This is a completely new symptom description unrelated to her just-prior talk, yet the turn initial

“but yeah and...” builds it as a continuation of that turn. After the physician inspects the eyelid and confirms “I can see that. yeah” in line 27, the patient adds “um... ’n yeah but other than that it hasn’t been... bothering me.” This constitutes further volunteered information about the patient’s problem, again built as a continuation of her prior talk with “’n yeah but...”. At the same time, however, the information added is somewhat generic and actually pulls back from her prior bids for a return to diagnostic inquiry by casting the problem as *not* a problem. This bids for closure of the ongoing sequence (Schegloff 2000a), and mirrors some of the practices patients use to indicate that their problem presentation is over and the physician has “missed” the relevant place to take up the information and begin history-taking (Heritage & Clayman 2010).

Indeed, as I discuss more in Chapter 3, each completion point of volunteered information creates a space where a physician might relevantly take up or respond to the patient’s action. In this case, the physician has primarily treated the patient as unfinished with a series of minimal acknowledgment tokens, and even when she leans in to re-inspect the patient’s eyelid, she closes this activity with a mere confirmation that she sees what the patient is referring to (“mm hm I can see that yeah” in line 27) but no further comment, diagnostic or otherwise. The patient’s incrementally added informings may thus be locally emergent pursuits of more substantive uptake or response. But regardless of whether volunteered informings are locally emergent or part of a patient’s project to get this information “on the table” (McArthur 2018), when patients have already been engaged in renewed talk about their problem, that talk provides a local interactional resource for further volunteered information, even when that information is unrelated to the prior. While tying back to that talk does not necessarily cast this additional information as warranted, it does somewhat mitigate the hearable inappositeness of the volunteered information in the context of counseling.

Another way patients mitigate the hearable inappositeness of volunteered information-giving is through turn prefaces that cast their turn as an explanation or account for their initial presentation

of the problem. These prefaces include “because” and “I mean,” which cast some volunteered information as unpacking or otherwise explaining some prior statement of a problem; “I was just like...” (e.g., “I was just like why is it taking this long to heal”) which accounts for some interpretation of the problem that motivated the visit in the first place; and “it’s just...” (e.g., “it’s just the discoloration, the white spots”), which somewhat more obliquely ties back to or accounts for the problem presentation by highlighting a symptom that may have motivated the visit in the first place. Depending on the local interactional context, the patient may precede these prefaces with a quick *okay* or *yeah*, taking up and aligning with some prior physician assertion by displaying reciprocity in the most minimal way before pivoting to this new matter (Jefferson 1993).

Unlike in the previous extract, where the patient tied back to some local, locatable prior utterance, volunteered information prefaced in these ways “do” tying back without specifying or making observable to what in particular they’re tying. Although in many cases this new volunteered information may be quite distal to any prior patient talk about their problem, in Extract 19 the two are closer together in time because the physician’s investigation of the problem is short. This allows us to see that in many cases there *may be no* relevant prior talk that the patient’s new volunteered information is unpacking.

The patient’s primary concern in this visit is an upper respiratory infection. After that problem is resolved, the physician solicits a secondary problem with “then you have some weird thing going on with your leg?” (not shown); the patient describes “bulgy” veins, which the physician diagnoses as varicose veins. Just as he initiates an explanation of that condition, she adds “and I don’t know if I ever showed you this” in line 1, lifting her ankle into the physician’s view and taking off her shoe to pull down her sock. As the physician leans in to inspect her ankle, the patient adds “but like- am I alr- am I gonna live” in line 7, plus some candidate causal explanations and an explicit request for diagnostic explanation with “is it diet, is it alcohol, is it marijuana, what am I

doing” in lines 10-15.

(19) AMH 02-16 Problem presentation through to counseling

1 PAT: And I don't know if I ever showed you this:.
2 (0.5) ((PAT lifting ankle into DOC's view))
3 PAT: But like this is pretty #wonky.#
4 (0.8) ((PAT taking off shoe))
5 PAT: But again it doesn't hurt.
6 (0.5) ((DOC leans in to look))
7 PAT: But like- (.) [Am I alr- Am I gonna live, eh-hh=
8 DOC: [°Yeah° ((looking at ankle))
9 DOC: You're gonna live.
10 PAT: \$Okay.\$.hhh Is [it die:t,
11 DOC: [h Yea:h
12 PAT: Is it [(.) alcoho:l,
13 DOC: [Well it's- your t-
14 DOC: .tlk .hhh
15 PAT: Is it marijuana:, what am I \$doing.\$
16 DOC: No:,
17 (0.5)
18 DOC: But you do: have some varicose veins (.) um some people
19 get these when they're young for reasons that are
20 unclear.=.hh This is something that happens to women
21 after they've had babies [a (.) a t- a time or two:
22 PAT: [((eye roll, knee slap))
23 DOC: definitely.=h and just as (.) as people age, .hh but
24 u:m (0.2) basically you've got a little bit of:=uh
25 (0.8) .tlk (0.8) what we call: incompetency of your
26 vein:s, (0.5) um: so the- (0.2) the pressur:e (0.5)
27 tends to cause a little distention in the veins here.
28 PAT: -> Okay.[<'cause sometimes m-
29 DOC: [And tha:t's what this [is here.
30 PAT: -> [it-
31 PAT: -> my legs and fingers fall asleep, (.) easier than
32 -> befor:e?
33 DOC: [Yea:h.
34 PAT: [But li:ke (0.8) is the[r:e-
35 DOC: [So um (0.8) [so there-
36 PAT: [working ou:t I
37 should just move around,
38 DOC: Yeah there- there's- .hh there isn- (0.2)
39 PAT: It looks [gross doesn't i:t?
40 DOC: [Your-
41 (0.2)
42 DOC: ^We:ll no I don't think it's gross [it- but it- but it's
43 PAT: [ehh heh
44 DOC: definitely: just uh (.) this is .hh this is what we
45 call a venous stasis change of the skin.

The physician rules these out with “no” in line 16, reasserts a diagnosis of varicose veins, and then provides some of his own causal explanations for the condition – that sometimes young people get them for reasons that are unclear (lines 19-20), sometimes it happens to women after

having babies (lines 20-21), and sometimes it just happens as people age (line 23). He then reformulates the diagnosis as “incompetency of your veins” in lines 25-26, initiating an explanation of this with “so the pressure tends to cause a little distention in the veins here... and that’s what this is here” in lines 26-29.

The patient accepts this diagnosis and explanation with “okay” but then rushes into an additional turn via abrupt-join (Local & Walker 2004) to volunteer additional information with “cause sometimes m- ... it- ... my legs and fingers fall asleep easier than before” in lines 28-32. The “because” preface here casts this turn as unpacking or explaining some aspect of her prior problem presentation. But we can see her whole problem presentation, and this symptom description is completely new and unrelated to anything she’s said so far. Thus this “because” is casting this turn as “doing” explaining without actually having anything relevant to tie back to.

On one hand, turn prefaces like “because” mitigate the inappropriateness of a volunteered informing by casting it as tied to some prior patient description of the problem that was, presumably, solicited or warranted by the activity context within which it occurred. On the other hand, even if there *were* some locatable talk in the problem presentation phase that these volunteered informings could be seen to unpack, this would constitute a return to information-gathering. Thus the very prefaces that may mitigate the inappropriateness of a volunteered informing at the same time mark them as indeed out of place in the counseling phase. Moreover, by acknowledging the physician’s prior talk in the most minimal way possible and then shifting to the patient’s own concerns with a preface like “because” or “I mean,” patients are somewhat obviously using a slot in a counseling context to shift away from the physician’s agenda and toward the patient’s own. Thus despite these “tie-back” prefaces, these types of turns are dissimilar to other practices I’ve illustrated. This is even more so the case with unwarranted symptom descriptions that have no prefaces, or whose prefaces explicitly cast the turn as inappropriate, e.g., “y’know,” “I have a question for you...”

and so on.

e. Distributions

Table 2 shows the distribution of diagnosis resistance directed toward the patient’s domain of lifeworld expertise.

Table 2
Distribution of diagnosis resistance in lifeworld domain

Resistant action type	<i>Frequency</i>	<i>Percent</i>
Designed as warranted		
Talk in Patient Domain	49	42%
Talk about Treatment	13	11%
Opportunistic Revelation	9	8%
Other/ Idiosyncratic	3	3%
Not designed as warranted		
Builds on just-prior symptom talk	20	17%
Prefaces “doing” tying back	16	14%
Completely unwarranted	8	7%
Total	118	102%

Note: percentage totals subject to rounding effects

We can observe that patients are, in general, doing work to volunteer symptom information in ways that mitigate the inappropriateness of their talk during counseling. More instances of resistance are designed as locally warranted (63%) than not. In many cases there is a local warrant in the ongoing conversation patients can legitimately tie to because they have some social and interactional rights to do so. By far the most common type of local warrant is the physician’s own prior talk in the patient’s domain (42%), which includes further history-taking, descriptions of symptoms, and expressions of empathy. Talk about treatment (11%) also provides a legitimate local warrant, as patients have some rights to discuss or even negotiate treatment (Lindström & Weatherall 2015; Stivers & Timmermans 2020). In other cases, as with opportunistic revelations (8%), patients create their own local warrant.

In the absence of a local warrant, patients work to tie their volunteered informings to their own prior talk – whether building on a locatable just-prior utterance (17%) or more vaguely being shown to tie back to prior concerns with prefaces like “because” (16%) – far more often than they allow their informing to stand completely unwarranted (8%). Regardless of whether the patient’s prior talk was itself unwarranted, or indeed cannot be located, this works to mitigate the hearable inappropriateness of the current turn relative to the ongoing activity. All of this work shows that, even when they are discussing matters in their own lifeworld domain, patients are oriented to the challenge presented by volunteering information during counseling and thus making a move to an activity context where the physician’s assessment may still be shaped.

2.4.2.3 The Intersection of Domain and Format

By formatting resistance in the clinical domain as questions, patients display an epistemic stance that they are unknowing (K-) about clinical matters while the physician is knowing (K+) (Heritage 2010). Likewise, assertions about symptoms or other aspects of the patient’s illness experience maintain an orientation to an epistemic gradient in the opposite direction, and the patient’s own primary rights to discuss such matters. These differences in format reflect differences in the patient’s stance toward their rights to know about matters in either domain.

These differences in format also affect the degree to which resistant actions constrain the physician to respond. As questions, actions in the clinical domain make response conditionally relevant, placing more constraint on the physician’s next action. In contrast, when patients resist a diagnostic assessment through an assertion of knowledge in their own domain, the constraint on the physician to respond is considerably lessened (see also Gill 1998; Gill & Maynard 2006). Physicians often do respond but, as I discuss in Chapter 3, they also sometimes ignore the resistance embodied in the patient’s turn. As a result of these domain-format pairings, questions in the clinical domain are

more overtly threatening both epistemically and interactionally, and assertions in the lifeworld domain are less so.

There are two types of resistant actions in the data which, on their face, do not fit the pattern between domain and format described above: symptoms that are raised in the form of a question, and candidate diagnoses that are raised in the form of an assertion. But the relationship between action features like domain and format are not deterministic; rather, such features can be reflexively used as resources for what a turn can accountably be heard to be doing (e.g., Heritage, Raymond & Drew 2019). In this case, the patterns of domain and format illustrated above can upgrade or downgrade the challenge a given action might otherwise present. Because assertions in the patient's domain present less of a threat to epistemic asymmetries and place less constraint on the physician to respond, framing something in the clinical domain *as* an assertion in the lifeworld domain downgrades its challenge. Likewise, framing something in the lifeworld domain as a question in the clinical domain upgrades the challenge to that diagnosis. Consider the following extracts.

a. Questioning Symptoms

Extract 20 illustrates an action in the patient's domain framed as a question in the physician's domain. Such actions almost always occur as a question about whether a symptom is "normal" for a given diagnosed condition, or whether the diagnosis indeed explains the symptom. In this visit, the patient has presented with persistent ankle swelling and stiffness after what he says was diagnosed in hospital as a "really bad sprain." During the problem presentation, he says he "would've thought that in the time period since it's happened, since icing it and taking Naprosyn" that he would not still have these symptoms. After information-gathering the physician delivers a diagnostic utterance that "it looks like you probably have some post-traumatic tendonitis in here related to the healing process and just, you know, the injury itself" (not shown). He then says that Naprosyn is "of limited

usefulness” and suggests physical therapy. After some intervening talk he is repeating this recommendation for physical therapy in lines 1-4. As the physician is about to move on from this (“okay and then uh” in line 6), the patient asks “is it unusual for it not to hurt” in line 9. After a significant gap he pursues response by adding “but yet to still... be symptomatic like this” in line 11.

(20) PCT 19-06 Counseling

1 DOC: Well=I- (0.5) Let's have you see the physical
2 therapist and see what [the physical therapist
3 PAT: [(clears throat)]
4 DOC: has to say about it.
5 PAT: Oka[y.
6 DOC: [Oka:y, And then u::h (0.5) u::m (1.0)
7 PAT: hhhhh
8 (0.8)
9 PAT: -> Is it unusual for it no:t to hurt,
10 (0.5)
11 PAT: -> But yet to still: (0.8) be symptoma:tic like this,
12 (2.5)
13 PAT: I mean because it's not pain:ful.=In the
14 mornings [when I wake [u:p,
15 DOC: [Not- [Not particularly unu:sual no:.

Like the patient informings illustrated in the previous section this action topicalizes symptoms, which are substantively in the domain of lifeworld knowledge. But when patients merely assert the presence of symptoms (e.g., if the patient here had said “it doesn’t hurt, but is still symptomatic”), they not only refrain from making any explicit connection between the symptom and the physician’s diagnostic assessment, they also place no overt constraint on the physician to respond. As I mentioned above, this means physicians can – and often do – not take up the patient’s resistance. In contrast, by asking whether his symptoms are “unusual,” this patient questions the typicality of his illness experience relative to the broader set of ankles diagnosable as post-traumatic tendonitis. This begins to enter the clinical domain by engaging in diagnostic reasoning. Further, by asking a yes-no question, the patient introduces at least the possibility of a response disconfirming the assessment and constrains the physician to minimally confirm the fit between the assessment and the patient’s

experience. By doing so, the patient resists the physician's assessment in a way that is more of a threat to epistemic and interactional asymmetries than symptoms presented as assertions.

b. Asserting Candidate Diagnoses

The following extracts illustrate actions in the clinical domain framed as assertions in the lifeworld domain. Patients do this in three ways. First, as shown in Extract 21, patients suggest candidate diagnoses framed in an informing about another person's illness, implicitly suggesting that the patient may have the same thing because they are related (i.e., a genetic link), because they socialize in close proximity (i.e., a contagion), or because they have similar symptoms. In this visit, the patient describes a family history. During the problem presentation, the patient complained of pain like "lightning bolts" shooting down the back of his leg when he walks, and explicitly suggests sciatica as a candidate diagnosis. At that time, the physician agreed that it "sounds like sciatica" (not shown). At the end of the physical exam, the patient pre-empted the move to counseling by asking about a cortisone shot. The physician continues this activity, and in line 1 below is concluding talk about a referral for physical therapy. Just as he is about to move on ("pt" in line 5), the patient mentions that his mother and grandmother had rheumatoid arthritis in lines 6-7.

(21) AMH 01-15 Counseling

1 DOC: So I'm gonna place a referral for that too.
2 (0.5)
3 PAT: Okay.
4 (0.5)
5 DOC: .pt ((gesturing toward computer))
6 PAT: -> So: my mother:, (0.2) and my: grandmother::
7 -> were both rheumatoid arthritis?
8 DOC: Okay,
9 (0.8)
10 PAT: -> S:o::=I guess I'm in the gene pool for tha:t,
11 DOC: Mm hm:,
12 PAT: -> Would that have?
13 (1.2)
14 DOC: [.hh
15 PAT: -> [Is that a possibility here,
16 DOC: That's a good question:. u:m So in your? ca:se?
17 (0.2) u:m it's it's pretty unlikely.

18 (.)
19 DOC: based o:n=u:h my exam.
20 (0.2)
21 PAT: Okay,

Unlike candidate diagnoses presented as questions as in Extract 10, statements like this do not pose a question to the physician. Rather, they are framed as an informing that looks like any other description of a symptom or another aspect of the patient's illness experience and history. In this sense, they are designed as A-event statements, just like other actions in the lifeworld domain. As I discuss further in Chapter 3, physicians may indeed treat such statements as mere informings. The physician does that here, with a rising-intoned "okay" in line 8 and "mm hm" in line 11, receipting the information without (dis)confirming the candidate diagnosis or otherwise taking up a possible link between it and the diagnosis of sciatica. Nonetheless, because diagnosis is a clinical matter, the disparity in epistemic status between the knowing physician and the unknowing patient makes physician response relevant (Labov & Fanshel 1977; Heritage 2012). In this case, the patient indeed pursues response in line 15 with "is that a possibility here" revealing his reasoning that he may have rheumatoid arthritis and orienting to his prior statement as response relevant.

The second way patients frame candidate diagnoses as assertions in the lifeworld domain is by providing an account for why they came to the doctor. Consider Extract 22. In this visit, the patient presented with back pain. In the problem presentation he said he "initially thought it was my sciatica acting up" but that the pain now reaches around to his groin (not shown). He adds that he took some Excedrin PM, felt better, and was debating whether or not to come, but "my wife forced me to come" (not shown). The physician moves into counseling with "I think it's your back acting up" and when the patient requests confirmation that he means sciatica, he elaborates with "I would call it more lumbo-sacral strain" (not shown). After recommending treatment and discussing possible causes of the strain, the physician begins writing notes in the patient's chart in line 1. As he does this, the patient adds that his "wife insisted it was a kidney infection" in lines 2-3.

(22) PCT 21-07 Counseling

1 ((DOC writing in chart))
2 PAT: -> B't- u:h my wife insisted it was a kidney
3 -> infection. \$hhh\$ ((through nose))
4 (.)
5 PAT: °I was doomed.=hh°
6 (0.8)
7 DOC: I don't think it is:,
8 (.)
9 DOC: U:m, (0.5) we can get a urine sample and check
10 it [just to make sur:e,
11 PAT: [((nods))

This utterance provides an account for why the patient has come to the doctor, rather than directly asking the physician to consider an alternate diagnosis as in Extract 8. Although this account invokes a third party, others do not (e.g., “I just wanted to make sure it wasn’t diabetes”).

Unsurprisingly, such accounts most often occur in the context of no-problem or routine/self-limiting diagnoses, and deal with two things at once – checking that the problem isn’t something more serious, and justifying the patient’s decision to come to the doctor in the first place (Heritage & Robinson 2006a)

Like informings of family history, accounts for the visit take something in the clinical domain and move it slightly into the lifeworld domain, because they are descriptions of the thought process that led the patient to come to the doctor, rather than assertions of an actual possible alternate diagnosis. Nonetheless, they do put forth a diagnostic hypothesis, which is within the physician’s epistemic domain and thus mobilizes response. In this case, the physician tentatively rules out a kidney infection in line 7, offers a diagnostic test in lines 8-9, and repeats his original diagnosis in line 12. And although the patient had originally oriented to his wife’s worry as laughable (through a smiley laugh-exhale through his nose and a mock-catastrophizing “I was doomed” in line 5), he now reveals an orientation to the candidate diagnosis as indeed investigation-relevant by nodding in agreement with the offer for a test in line 11. Thus, although the patient’s action on the surface merely deals with legitimacy issues, both physician and patient orient to it as also renewing

the relevance of diagnostic investigation.

The final way patients frame candidate diagnoses as assertions is by simply asserting their opinion or belief that a given diagnosis or etiology *is* the cause of their symptoms. Unlike candidate diagnoses framed as family history or accounts for the visit, these are not hearable as A-event statements, and thus risk being heard as *much* more on-record challenges to the physician's expertise. It's important to note, however, that these typically occur in contexts where the physician has not named an official diagnosis – either because they've recommended a diagnostic test or because they've ruled out serious illness without actually naming an alternate diagnosis – or where the patient is proffering some etiological explanation rather than a competing diagnosis *per se*. Thus, what patients are typically doing is making a bid for further diagnostic assessment rather than challenging a particular diagnosis. Consider Extract 23.

Earlier in this visit the physician went over some of the patient's bloodwork results, mentioning during this that he is pre-diabetic, meaning his blood sugar is elevated but does not yet rise to the level of diabetes. Later the patient describes a "lumpy" feeling in his foot. The physician does not diagnose this problem but says after physical examination that the foot "feels pretty normal" (not shown), implicitly ruling out anything serious and orienting to the reported sensation as no problem. The patient takes this up with "so it's nothing" (not shown), and then begins discussing his experience with a chiropractor who's been helping him with his feet. He finishes this telling with "I just did wanna make sure that it's not something with diabetes or something like that" (a candidate diagnosis framed as an account; not shown). The physician disconfirms and the patient pursues by asking "what *are* the symptoms of diabetes" (not shown); the physician lists some, including numbness in the feet, which the patient confirms having. This prompts a somewhat lengthy investigation of this symptom, with the physician treating this as distinctly different from the "lumpy" feeling. At the end the physician recommends some additional blood tests, adding that his

“working guess” is that the numbness “might be related” to pre-diabetes, and that their “plan should be weight loss to cure the pre-diabetes” (not shown).

Following this recommendation the patient returns to his concern about the lumpy feeling in his foot, requesting re-confirmation that this is “not something you would associate with diabetes” in lines 3-4, and the physician disconfirms with a head shake in line 5. The patient accepts this with “okay” in line 6, and then adds an asserted candidate diagnosis: “so my guess is that whatever that is, ’n whatever’s causing it, which he [the chiropractor] argues you know the knee bone’s connected to the thigh bone kind of argument... is that the numbness is connected to that” (lines 6-11). The grammar of this asserted diagnosis is a bit convoluted because of the focus on “whatever that is, ’n whatever’s causing it” at the beginning of the utterance and the inserted background on what the chiropractor has told the patient (“which he argues...”). To simplify a bit for the sake of highlighting the declarative structure of this turn: “my guess... is that the numbness is connected to that [the lumpiness].”

(23) AMH 01-05 Counseling

1 PAT: Okay now see the- the- the feeling of the
2 lumpiness in the foot. (0.8) U:m: (1.0)
3 u:h (1.2) that strikes- that's not something
4 that you would associate with diabetes right,
5 DOC: ((shakes head))
6 PAT: -> Okay. .h So my th- guess is that- that whatever
7 -> that is 'n whatever's causing it (.) which he:
8 -> argues you know (0.5) the knee bone's connected
9 -> to the thigh bonekind of hhh (h)argument. .hh
10 -> U:m: (0.5) is: (.) uh is that- (.) the numbness
11 -> is c- is connected to that.
12 (1.0)
13 PAT: But- I mean- but it may not be. 't ma:y it may
14 be something else (that's not connected).
15 (1.0)
16 DOC: It can: cause- neuropathy can cause (0.5) pain.
17 (0.5)
18 PAT: Uh huh,
19 DOC: too. Discomfort. So it might be related.
20 PAT: Yeah.

This candidate diagnosis makes a bid to connect the feeling of lumpiness in the patient’s foot

with the numbness just investigated by the physician, which the physician observably treated as separate. Unlike the prior two examples, this candidate diagnosis is framed merely as the patient's own diagnostic reasoning and is not framed as something in the patient's lifeworld domain. This makes it a B-event statement rather than an A-event statement in this particular social context, as it is the physician who would know, more so than the patient, whether the lumpy feeling and the numbness are connected. Physician response is thus relevant, which the patient orients to with his pursuit of response after a 1-second silence, with "But I mean it may not be... it may be something else that's not connected" in lines 13-14.

On one hand, interrogative question formats display an orientation to the physician's primary clinical expertise, whereas an assertion makes no such display. Moreover, declarative question formats display stronger epistemic commitment to a state of affairs than interrogative formats (Heritage 2012). For these reasons candidate diagnosis assertions that are not framed in the lifeworld domain may be hearable as stronger challenges to a physician's expertise than questions. But whereas questions constrain physicians to respond, musing-like assertions like this one, on their surface, do not. In a context where the physician has repeatedly chosen *not* to diagnose the patient's problem, a question like "so is the lumpiness connected to the numbness?" or even "so what is causing the lumpy feeling?" would more strongly request diagnostic comment than an assertion like this one. Thus, in this context the assertion format may mitigate the challenge to the physician's expertise relative to candidate diagnoses framed as questions.

c. Distributions

The characteristics of domain and action format can be resources for calibrating the challenge an action presents to interactional and epistemic asymmetries. Although framing an action in the opposite domain does not *put* the action in that domain, it does pull it closer toward it. Thus,

actions in the clinical domain framed as assertions in the lifeworld domain downgrade the action's threat to epistemic and interactional asymmetries, whereas actions in the lifeworld domain framed as questions in the clinical domain upgrade the challenge to the physician's diagnostic assessment.

Table 3 shows the frequencies of diagnosis resistance types that cross domain types via format and content.

Table 3
Distribution of diagnosis resistance types crossing domains

Resistant action type	<i>Frequency</i>	<i>Percent</i>
Candidate diagnoses framed in lifeworld domain	16	47%
Symptoms framed as questions	10	29%
Asserted candidate diagnoses	8	24%
Total	34	100%

2.4.2.4 Summary

In the foregoing analysis I illustrated my collection of diagnosis resistance types in the data: (a) inquiring about a diagnostic test, (b) questioning exam or test findings, (c) inquiring about a candidate diagnosis, (d) requesting a diagnostic assessment, and (e) describing symptoms or other aspects of the patient's illness experience. I split these action types into three main categories: those which substantively fall in the domain of clinical knowledge and are formatted as questions (a-d); those which substantively fall in the lifeworld domain and are formatted as assertions (e); and those which cross domains by framing something substantively in one domain, e.g., a symptom description, in the format of the other domain, e.g., a question.

By definition, all of the actions in this collection threaten the initiative aspect of local interactional asymmetries (they stall forward progressivity), and structural asymmetries (they reverse progressivity by renewing the relevance of information-gathering). Indeed, patients do work to

mitigate these two threats across all action types, for example: initiating resistant actions during lulls in the talk, such as when the physician is typing on the computer (Extract 7), looking at paperwork (Extract 13), or writing in the patient's chart (Extracts 22); and initiating turns with prefaces indicating a continuation of prior talk, e.g., 'so' (Extracts 7, 9, 11, 21, 23), which marks the turn as an inference drawn from the physician's talk (Blakemore 1988; Bolden 2006); 'and' (Extracts 8, 12), which marks it as a 'next item' in the ongoing activity (Heritage & Sorjonen 1994); and 'but' (Extract 22), which marks it as an extension of the patient's own prior talk. In cases where such prefaces are not used, turns may be designed in other ways as touched off by something the physician was just saying, e.g., through last-item onset overlap (Extracts 10, 14) and locally subsequent reference terms (Extracts 17, 18, 20). These design features mitigate both the stalling and reversing aspects of all resistant actions.

But there are important differences between actions in these three categories. I argue that questions in the clinical domain present the most overt threat to the physician's authority because they directly threaten epistemic asymmetries and place more constraint on the physician to respond. This is reflected in the design of resistant actions in this domain, as patients do extra work to mitigate these threats, for example by designing their questions to grammatically prefer a response that confirms the physician's original assessment and displaying relevant clinical knowledge that somewhat accounts for their incursion into the physician's domain of expertise.

In contrast, assertions in the lifeworld domain present the least overt threat to the physician's authority, to the extent that they may not always be accountably hearable *as* resistance. This is even more so the case when patients design their actions as warranted by the physician's own talk in their domain, by sudden internal sensations, or by discussions about treatment. Unlike questions in the clinical domain, assertions in the lifeworld domain place the least constraints on the physician to respond. And as actions in the patient's own epistemic domain, they only threaten the

physician’s epistemic authority indirectly, via the move they make to an activity context where the physician’s assessment may still be shaped.

Actions which cross domains lie somewhere in the middle in terms of how overtly they challenge the physician’s authority. When actions in the clinical domain are framed as assertions in the lifeworld domain, the action’s threat to epistemic and interactional asymmetries is downgraded; conversely, when actions in the lifeworld domain are framed as questions in the clinical domain, the challenge to the physician’s diagnostic assessment is upgraded.

Table 4 shows the broad breakdown of resistant actions within these categories.

Table 4
Distribution of all instances of diagnosis resistance across domain types

Resistant action type	<i>Frequency</i>	<i>Percent</i>
Lifeworld Domain	118	64%
Cross-Domains	34	19%
Clinical Domain	31	17%
Total	183	100%

Assertions in the lifeworld domain are by far the most common (64%), with the remaining actions nearly equally divided between actions in the clinical domain (17%) and actions that cross domains (19%). This finding shows that although patients *are* resisting physicians’ diagnostic assessments more often than previously thought, they are doing so carefully, relying primarily on actions which substantively fall in their own domain of lifeworld expertise, and which interactionally place the least constraints on physicians to respond. This is underscored by the work patients do to mitigate the inappropriateness of their resistant turns, and to design some actions in the lifeworld domain as locally warranted and so far off-record that they are not accountably hearable *as* resistance. That patients are resisting so often but so carefully suggests that they do indeed have lingering concerns about their condition and its assessment; however, this is fraught work, and the extent to which patients work to remain deferential to the physician’s authority may in fact

undermine their own efforts to get their concerns addressed before the close of the visit.

2.5 DISCUSSION

In this chapter I have operationalized diagnosis resistance in primary care visits for new or acute problems as *any patient action which, at any point during counseling, not only stalls but initiates reversal of the visit's progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped*. Although actions thus defined as resistant enact a reluctance to accept or go along with a diagnostic assessment, they do *not* necessarily index disagreement or rejection of that assessment. Nonetheless, by in some way inviting reconsideration of the fit between the physician's assessment and the patient's experience after the shift to counseling, diagnosis resistance presents an implicit challenge to physicians' medical authority and risks undermining the nature and purpose of the visit.

This operationalization differs from prior accounts of diagnosis resistance, which focus exclusively on how resistant actions challenge and stall progressivity away from a diagnosis. Instead, my operationalization identifies resistance through a kind of objective hermeneutics turning on the structural organization of acute care visits and the position diagnostic assessment occupies in that organization. Because information-gathering activities are recognizably leading up to a moment of assessment and counseling activities are recognizably subsequent to and contingent on one, any move a patient makes to initiate a return to pre-assessment activities crosses into an activity context where the physician's assessment may still be shaped, treating that assessment as unsettled. The novelty of my operationalization is that this reversal of progressivity is *definitional*; it is a necessary and sufficient condition.

This operationalization is significant because it captures actions in a wider range of positions and formats, than prior accounts of diagnosis resistance. Most importantly, it makes it possible to

capture resistance of diagnostic assessments that do not consist of an explicit diagnosis *per se*, which are common in primary care (Heritage & McArthur 2019; see also Chapter 1 of this dissertation), and it liberates the analysis from the confines of the response slot in diagnosis sequences, capturing resistant actions occurring at any point following a diagnostic assessment up to and including visit closings. It also captures a wider range of action types than prior accounts, which vary in how overtly they threaten local and interactional asymmetries, and the extent they are obviously resistant in the first place. By combining these actions together under the banner of “resistance,” this study is able to examine the multifaceted ways patients work to get their lingering concerns addressed post-assessment in a deeply asymmetrical social and interactional context where they have no option for passive resistance.

The fact that my proposed operationalization turns on the structural organization of primary care visits and patients’ practices for returning to pre-assessment activities highlights what is likely an interactional resource for patients in this context: the fact that the information in/ information out structure of visits is organized around a diagnostic assessment means that any time a patient points out or introduces some bit of information about their condition during counseling, however covertly in terms of their motivation for doing so, they at least potentially make relevant reconsideration of the fit between the physician’s assessment and the patient’s experience or expectations. This is a tool patients may use to work toward resolution of their lingering concerns without overtly challenging the physician’s epistemic primacy to assess their problem in the first place.

Prior studies taking a narrower approach to diagnosis resistance – i.e., focusing only on direct responses challenging explicit diagnoses – have found that resistance is rare in primary care. In contrast, my conceptualization and operationalization of resistance shows patients in primary care resisting diagnostic assessments far more often than previously supposed – in as many as 4 out of 5 visits for new or acute health problems. Thus, in a vast majority of cases, patients are not

“surrendering their private judgment” (Starr 1982) or accepting diagnostic assessments “on authority” (Parsons 1951), both of which have been considered key ways patients maintain an orientation to the physician’s epistemic primacy in clinical encounters. In an historical context where patients are becoming more engaged in their own medical care (Timmermans 2020) and there is growing consensus that healthcare should more adequately attend to, respect, and treat as central the patient’s perspective (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992; Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Mishler 2005; Illingworth 2010; Silverman, Kurtz & Draper 2013), this is perhaps neither surprising nor problematic.

However, unlike with treatment (Stivers & Timmermans 2020), patients are not engaging in flat-out negotiation with physicians over their diagnostic assessments. Rather, as I have shown in this chapter, patients are resisting carefully, relying primarily on actions which substantively fall in their own domain of lifeworld expertise and which interactionally place the least constraints on physicians to respond, and doing extensive work to mitigate the inappositeness of their resistant turns and the challenge they may present to the physician’s authority. Indeed, in some cases patient resistance goes so far off-record that it is not accountably hearable *as* resistance. The operationalization proposed in this chapter, which is based solely on patients’ return to information-gathering rather than the overtness through which patients actually disagree with or challenge diagnoses, is analytically useful because it helps capture and describe even these most covert types of resistance.

As I show in the next chapter, however, the problem with resisting so covertly, from the patient’s perspective, is that it may be easy for physicians to ignore their resistance (if they recognize it *as* resistance) and maintain progressivity toward closing without pursuing or addressing their underlying concerns. Indeed, although the sheer rate of diagnosis resistance may challenge the notion that physicians’ epistemic is not “under siege” (Stivers & Timmermans 2020), the fact that

patients are resisting in ways that ultimately defer to the physician suggests that patients' *orientation* to physicians' authority is undermining their very efforts to get their concerns addressed. This suggests that, as patient-centered care advocates have noted, physicians may need to take a more active role in pursuing patient concerns. It also suggests that physicians' medical authority in clinical encounters may be in something of a liminal state, where a rise in patient empowerment and engagement is pushing up against a legacy of paternalism enacted through a deferment to physicians over clinical matters like diagnosis. I will consider this issue in more depth in the conclusion of this dissertation (Chapter 5), after painting a fuller picture of diagnosis resistance by looking at how physicians respond (Chapter 3) and the contexts where patients are most likely to resist in the first place (Chapter 4).

CHAPTER 3:

How primary care physicians respond to diagnosis resistance

3.1 INTRODUCTION

As laid out in the previous chapter, my proposed operationalization of diagnosis resistance in acute primary care visits is *any patient action which, at any point during counseling, not only stalls but initiates reversal of the visit's progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped*. This operationalization identifies resistance through a kind of objective hermeneutics turning on the structural organization of acute care visits and the position diagnostic assessment occupies in that organization. It thus captures a range of patient actions beyond overt challenges to a diagnosis. It also brings into focus the interactional resource patients are ultimately drawing on to interrupt the progressivity of a visit in service of whatever lingering concerns they may have about how their problem is being assessed.

Turning the crank one step forward, this operationalization – and the concepts of normative epistemic and interactional asymmetries underlying it – also sheds light on the social and interactional position diagnosis resistance puts physicians in. Regardless of patients' underlying motivations for resisting accepting or going along with a physician's diagnostic assessment, by interrupting counseling to make a move to an activity context where the physician's assessment may still be shaped, they implicitly challenge physicians' interactional authority to have moved into counseling, as well as their epistemic authority to have assessed the problem in the first place. From overtly resistant actions like questioning the evidence to mere renewals of a prior complaint, diagnosis resistance indicates some lingering patient concern(s) about their condition or its assessment. It also creates a response slot where reconsideration of the patient's problem, reassertion of the original assessment, or at least pursuit of the patient's concerns underlying their

resistance is at least potentially relevant before resuming counseling activities. This move backward is happening in a context where physicians have limited time to spend with each patient and have already begun an observable move toward closing the visit.

With these matters in mind, this chapter considers the social and interactional sequelae of moments of diagnosis resistance. Specifically, how do physicians respond, and how do their responses shape the way the rest of the visit unfolds? I find three categories of responses in the data: brush-offs, physician-centered responses and patient-centered responses. With brush-off responses patient actions are interactionally bypassed without being treated *as* resistance. These actions typically afford the fastest return to the physician's interactional agenda. In contrast, physician- and patient-centered responses do treat a patient's actions as resistant, either by pushing back against it or to varying degrees aligning with the patient's invitation to return to information-gathering and/or reassessment. With physician-centered responses physicians work to move past the resistance and return to their clinical agenda as quickly as possible, while with patient-centered responses they work more expansively to acknowledge or address patient concerns before moving on.

After examining the patterning of these response types across visits, I argue that physicians tend to prioritize maintaining progressivity and their own agenda over responses that attend to or otherwise pursue patient concerns. This may in part be driven by institutional constraints, especially on the time physicians are allotted for patient visits. But I will argue that this trend is also shaped by how patients resist in the first place, with physicians more likely to brush off the least overt types of resistance. As I showed in the previous chapter, these types of resistance are the most common, and are sometimes so far off-record they may not be accountably hearable *as* resistance. Patients may thus be resisting most often in ways that are the easiest for physicians to brush off or respond to in a more physician-centered way. On one hand, this is a resource for patients to maintain deference to the physician's epistemic and interactional authority, even while attempting to raise lingering

concerns. But, as I show at the end of this chapter, patients are in general more likely to pursue response to their resistance than to abandon it, and this trend is strongest following brush-off responses. This suggests that whatever lingering patient concerns are driving diagnosis resistance, they are still not being addressed.

The findings from this chapter suggest that the state of medical authority, in primary care at least, may be in a sort of liminal state, where patients are more engaged (Timmermans 2020) and thus more likely to reason about their problems diagnostically and push to get their concerns addressed, yet they are undermining their own efforts by orienting to the minimal rights they have to indeed push back. And although an increasing push for patient-centered care would see physicians pursuing, discovering, and addressing patient concerns – *even* about diagnosis (Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Illingworth 2010; Silverman, Kurtz & Draper 2013) – this is not what physicians are doing in practice. These issues will be discussed further at the close of this chapter, and in Chapter 5.

3.2 BACKGROUND

In this section I describe the challenges diagnosis resistance implicitly presents physicians in two key areas: the threat to their authority and the threat to progressivity vis-à-vis a return to diagnostic inquiry.

3.2.1 Threats to Authority Presented by Diagnosis Resistance

There are broadly two types of authority at work in primary care clinical encounters: deontic and epistemic (Heritage 2021). Deontic authority is authority over determining a future course of action such as a course of treatment for an illness (Stevanovic & Peräkylä 2012; Lindström & Weatherall 2015). Primary rights to this authority are distributed between physicians and patients:

while physicians have the authority to recommend or prescribe treatments, patients have the authority – indeed, the control – over whether to carry out the recommended treatment. As a result, within clinical encounters, physicians and patients display a “shared orientation to patients having a normative obligation to endorse a treatment recommendation” (Stivers & Timmermans 2020). This shared orientation can be seen primarily in the ways physicians seek patient acceptance of a treatment recommendation before moving on toward visit closing (Stivers 2005, 2007; Koenig 2011). Indeed, taking a patient’s preferences and values into consideration in the course of determining a course of treatment is a pillar of shared decision-making and patient-centered communication (Langberg, Dyhr & Davidson 2019). In practice, when patients resist a treatment recommendation, either actively (explicit pushback) or passively (withholding response), a negotiation ensues (Stivers 2007; Stivers & Timmermans 2020). Although physicians are typically able to persuade patients to agree to the original recommendation, resistance can always potentially lead to a different course of treatment (Stivers & Timmermans 2020).

The second type of authority in primary care clinical encounters is epistemic authority, or “the distribution of rights and responsibilities regarding what participants can accountably know, how they know it, whether they have rights to describe it” (Heritage & Raymond 2005:18). In medicine, physicians have the epistemic authority to form a diagnostic assessment, and to determine the appropriate course(s) of action based on that assessment. As Starr (1982:13–14) puts it, physicians “evaluate the nature of reality and experience, including the ‘needs’ of those who consult them,” and this authority is “antecedent to action. By shaping the patients’ understanding of their own experience, physicians create the conditions under which their advice seems appropriate.” Unlike deontic authority, epistemic authority to diagnose a patient’s condition is the purview of the physician alone, based on knowledge gained during their medical training and experience in practice – knowledge which is “possessed and controlled by the profession of medicine” (Heritage 2005b).

This is not to say patients have no part to play in the diagnostic process. Ever since Parsons (1951) cast patients as passive recipients of medical care rendered incapable of participating in the clinical process due to the insurmountable chasm between their and the physician's knowledge about medical matters, social scientists and conversation analysts have worked to illustrate that patients do actually come to clinical encounters with a wealth of knowledge, experience, and theories about their illness (e.g., Mishler 1984; Kleinman 1988; Frankel 2001), and indeed participate in diagnostic sense-making, albeit from a displayed position of reduced interactional and epistemic authority over clinical matters *per se* (e.g., Stivers & Heritage 2001; Gill, Pomerantz & Denvir 2010; McArthur 2018). Moreover, work in the clinical realm has shown that when physicians elicit and take into consideration patients' self-diagnoses or other theories of their illness, diagnostic accuracy may be improved (Frankel 2001), along with patient self-care and compliance (Jutel 2010). The Institute of Medicine (2015), along with other proponents of patient-centered care, have explicitly recommended physicians do this in order to improve diagnosis in medicine. Parallel work on "concordance" in medicine similarly recommends that physicians take into account patients' experience-based knowledge about their illness, and work to reach mutual understanding about the patient's problem as a routine part of clinical encounters (Bissell, May & Noyce 2004; Ijäs-Kallio, Ruusuvuori & Peräkylä 2010).

There is also conversation analytic work showing that the move to patient-centered care – among other countervailing forces, including shifts in patient attitudes such that they are more informed, empowered and engaged than ever (Timmermans 2020), are taking a more consumerist approach to healthcare (Timmermans & Oh 2010), and are approaching their relationship with physicians as something more akin to a client-provider relationship than an authoritarian one (Reeder 1972; Stivers & Timmermans 2020) – may be tipping the scales somewhat in terms of how physicians' wield their diagnostic authority in visits with patients. We have moved away from a time

when physicians delivered diagnoses in a way that wields the power not only to determine a diagnosis but to have patients accept that diagnosis “on authority” (Parsons 1951; see also Byrne & Long 1976). Rather, physicians have been shown to display a certain amount of accountability to patients for the evidential basis of their diagnostic assessments in their online commentary during physical exams (Heritage & Stivers 1999) and the downgraded and evidentialized ways they design their diagnostic utterances (Heath 1992; Peräkylä 1998; Heritage & McArthur 2019).

But despite these signs that patients’ perspectives carry more weight in the diagnostic process than previously supposed, the fact remains that, unlike with treatment recommendations, neither patients nor physicians orient to patients as having the rights or obligation to endorse, reject, or negotiate a diagnostic assessment (Heath 1992; Heritage & McArthur 2019). Patients thus have no legitimate grounds on which to resist an assessment once it has been delivered.

In their paper on diagnosis resistance in Finnish primary care, Ijäs-Kallio, Ruusuvuori and Peräkylä (2010) paint a somewhat rosy picture of diagnosis resistance, describing it as an attempt on patients’ parts – which physicians primarily align with – to “further a shared understanding with their doctor on their condition.” While this may technically be true, the study understates the challenge to physicians’ epistemic and interactional authority that comes with diagnosis resistance. Despite the literature outlined above suggesting that patients do – and should – play a more active role in diagnosis, both physicians and patients continue to proceed through primary care encounters in a way that treats diagnosis as normatively non-negotiable. Indeed, by (however covertly) treating it *as* negotiable, patients risk threatening the very premise of their visit to the doctor – that they have a health problem they cannot solve on their own and need the physician’s expertise to resolve.

The entire structural organization of the visit as an institutionalized form of advice-giving (Jefferson & Lee 1981; Heritage & Sefi 1992) is based on this premise. The patient presents the problem, the physician investigates the problem, and the physician gives advice based on their

assessment of the problem. Regardless of patients' underlying motivations for engaging in diagnosis resistance – which, as discussed in Chapter 2, may not be to challenge a physician's assessment or authority *per se* – resistance presents physicians with an implicit challenge to their authority to assess the patient's problem and move on to counseling. This is one half of the distinct interactional difficulty diagnosis resistance presents for primary care physicians.

3.2.2 Threats to Progressivity Presented by Diagnosis Resistance

The second difficulty physicians face when confronted with diagnosis resistance has to do with progressivity. As discussed in Chapter 2, physicians have the interactional authority to direct the movement of the visit from one activity to the next and, more specifically, to determine whether and when information-gathering is sufficient to make an assessment and move into counseling. On one hand, this authority is intimately intertwined with epistemic authority, as it is the physician's clinical expertise and training that informs the decision that the differential diagnosis is sufficiently complete (or good enough for now) and counseling can commence. By inviting reconsideration of the fit between the physician's assessment and the patient's experience or expectations, diagnosis resistance implicitly threatens that authority. But there is also a second, perhaps more salient reason that a patient's bid to reverse the progressivity of the visit presents an interactional challenge for physicians: it takes time to move backwards and/ or address whatever patient concerns may be underlying their resistance.

There is some debate over whether physicians in various fields actually have a sufficient amount of time with patients, or whether a "sufficient" amount of time can even be objectively measured across the diverse array of patients and problems physicians (especially in primary care) may deal with in a given day (Braddock & Snyder 2005). Nonetheless, the amount of time physicians have with patients is strictly controlled by the healthcare organization where they work, with many

primary care physicians only given a maximum of fifteen minutes to visit with each patient (personal observation during data collection). More importantly for this study, research on this topic has found that both physicians and patients *perceive* the time they are allotted for an office visit as inadequate (Braddock & Snyder 2005). For physicians, inadequate time means constantly running behind, skipping breaks for follow-up phone calls, and documenting visits into the evening or during visits (personal observation during data collection). It has also been tied to physician burnout (O’Connell, Youcha & Pellegrini 2009) and a perception of patients who take more time as difficult (Elder, Ricer & Tobias 2006).

Some scholars worry that perceptions of inadequate time “may cause physicians to forego activities and behaviors that promote important aspects of the patient-physician relationship” (Braddock & Snyder 2005). Indeed, there is a pervasive clash, well-known among health communication scholars, between evidence-based recommendations for improving doctor-patient communication, and the fact that these may not be implemented because of a perceived lack of time to do so by physicians (Mauksch et al. 2008). This extends to some of the issues related to diagnosis discussed above – according to the Institute of Medicine (2015: 164), “a major concern cited by healthcare professionals is a lack of time to truly engage patients in the diagnostic process.” That physicians may not be taking the time to involve patients in this process as much as patients prefer could be one reason we’re seeing so much diagnosis resistance in the first place. But all of this additionally points to the fact that diagnosis resistance presents a challenge for primary care physicians not only in terms of the threat to their authority, but perhaps in a more immediately pressing way, in terms of time. If they already felt they didn’t have enough time to sufficiently care for and communicate with the patient, how do they deal with a patient action which, during counseling, bids for a move *backward* in the visit?

In the following analysis I show that physicians generally do *not* move backward in any

meaningful way, leaning toward responses that prioritize progressivity and avoiding more patient-centered responses that attend to or otherwise pursue patient concerns.

3.3 DATA

As in all chapters in this dissertation, this chapter draws on both the PCT and AMH datasets for observations and illustrative extracts, while all distributions and statistics are drawn from the AMH dataset. My unit of analysis consists of physician responses to diagnosis resistance in every “slot” where their response is indeed relevant. In some cases, as I show at the end of this chapter, patients pursue more satisfactory uptake or response to a prior instance of resistance with a new discrete instance of resistance. Each discrete instance of resistance produces a new slot for physician response, and so each response is counted and categorized separately (n=183 in the AMH dataset). In addition, patients sometimes pursue response with what I call a “bare” pursuit. These build on the prior instance of resistance and rely on it for meaning (e.g., turn increments), pursuing more satisfactory uptake or response from the physician without engaging in a new resistant action. Because these present yet another slot where a physician must respond to a patient’s diagnosis resistance, I have included responses to them (n=20) in my analyses for this chapter as well.

Because physicians can only relevantly respond to patient resistance if the patient has left space for a response, 6 cases were omitted where the patient obscures the response slot and quickly moves on to some other action or topic. Across the 70 counseling phases for diagnosable problems in the AMH dataset that contain at least one instance of resistance, there are a total of 197 analyzable physician responses.

3.4 ANALYSIS

3.4.1 *Types of Physician Responses*

In the first part of my analysis, I illustrate the three types of physician responses to diagnosis resistance found in the data: brush-offs, physician-centered responses and patient-centered responses. With brush-off responses patient actions are interactionally bypassed without being treated *as* resistance. These actions afford the fastest return to the physician's interactional agenda. In contrast, physician- and patient-centered responses do treat a patient's actions as resistant, either by pushing back or to varying degrees aligning with the patient's return to information-gathering or reassessment. With physician-centered responses physicians work to move past the resistance and return to their clinical agenda as quickly as possible, while with patient-centered responses they work more expansively to acknowledge or address patient concerns before moving on.

After demonstrating the key differences between these response types, I examine their frequencies in the dataset as a whole; how they are distributed across the resistance types described in Chapter 2; and how they pattern in sequences of resistance within single clinical encounters. Findings suggest that physicians tend to prioritize maintaining progressivity and their own agenda over responses that attend to or otherwise pursue patient concerns, but that this trend may at least partially be shaped by how patients resist in the first place, with physicians more likely to brush off the least overt types of resistance, which are themselves the most common.

In the last section of my analysis, I examine patient persistence qualitatively and quantitatively. I find that patients are in general more likely to pursue response to their resistance than to abandon it, and that this trend is strongest following brush-off responses. This suggests that, however off-record patient concerns remain in the design of their resistance and how physicians respond, there *are* lingering concerns driving patient behavior, and from the patient's perspective these are not being sufficiently addressed.

3.4.1.1 Brush Offs

With brush-off responses resistant turns are ignored, minimally acknowledged, or responded to but not treated as resistant actions. As the following extracts illustrate, brush-off responses are typically, though not always, produced in response to the least overt types of patient resistance, e.g., symptom descriptions that are designedly bound up with some locally emergent activity, or at the very least not hearably “doing” anything in particular, let alone resisting the diagnosis. By displaying an understanding of these actions as non-response-relevant or at least non-resistant, physicians interactionally bypass the invitation, however subtly embodied in the patient’s move to reverse the visit’s progressivity, to reconsider their assessment of the patient’s problem. This affords physicians the fastest return to their own interactional agenda compared to other response types.

a. Ignoring Resistant Turns

The most extreme way physicians brush off patient resistance is by ignoring the resistant turn entirely. This typically happens in two interactional environments. The first is when patients revisit symptom information they’ve already discussed while the physician is engaged in an entirely separate course of action – for example a physical examination activity or entering information into the patient’s chart. In these contexts, physicians may continue what they’re doing without acknowledging the patient’s turn at all, treating the patient’s talk as a non-response-relevant aside.

Second, as in the following extract, when patients engage in a series of resistant actions, physicians may initiate a course of action in response to one of those instances – e.g., asking a history-taking question or, as below, recommending a test – and then persist with that course of action in response to subsequent instances of resistance, effectively ignoring them. In this case the physician ignores a symptom description. Surprisingly, however, physicians also ignore more explicit types of resistance such as candidate diagnoses and requests for diagnosis.

In this visit the patient has presented multiple concerns, but the relevant one for this extract is a burning sensation in her hands and feet. The physician has explicitly expressed diagnostic uncertainty (“it’s an unclear story,” not shown), adding that “there may be some neuropathy, but there could also just be some forearm tendonitis and stuff that’s messing you up” (not shown). In response to this uncertain, somewhat non-specific and minimizing diagnosis, the patient resists seven discrete times. These all consist of symptom descriptions, some of which designedly contrast with the physician’s description of her problem, and some of which are new. After responding to many of these with minimal acknowledgments like “okay” and “yeah” (analyzed in the next section), the physician responds to the seventh with a recommendation for blood tests “to make sure there isn’t something else going on, like something inflammatory or something related to vascular issue” in lines 1-8 of the extract.

(1) AMH 02-18 Counseling

1 DOC: I would recommend we do some blood tests,
2 [to try to .hh make sure there isn't
3 PAT: [Okay.
4 DOC: anything else going on:, like something
5 inflammator[y:, or um (0.2) something
6 PAT: [Mm hm,
7 DOC: related to: u:h (.) .pt (0.5) vascular issue:
8 or some[thing,<which I don't think is the case.
9 PAT: [Yeah.
10 PAT: -> =I get inflammation in weird places.
11 (.)
12 PAT: -> Like (0.2) [again. (0.2) [my eyeballs.
13 DOC: [So you wanna- [So y-
14 PAT: -> You [kno:w,
15 DOC: [So you're okay if we go ahead and do the
16 testing.
17 PAT: Yeah.
18 (2.8)
19 PAT: Like the eye situation: doesn't usually happen:
20 (0.2) like I started getting it at twenty one?

Although this blood test directly addresses the patient’s concerns (we find out later she is worried about arthritis), the physician adds “which I don’t think is the case” in line 8. It is to this rule-out that the patient responds, working to revise his assessment that it’s not an issue of

inflammation with “I get inflammation in weird places” in line 10. After a beat of silence, she adds “like... again... my eyeballs” in line 12. By adding this more specific symptom detail, the patient more overtly renews the relevance of information-gathering. However, in overlap with this increment the physician begins to respond and then drops out twice with “so you wanna-” and then “so y-” in line 13. The patient adds a tag “you know” pursuing response in line 14, but again in overlap with this the physician maintains the trajectory of his prior turns, restarting and then completing his turn with “so you’re okay if we go ahead and do the testing” in lines 15-16.

“So”-prefaced turns are typically other attentive (Bolden 2006), and indeed this one could be heard to cast the turn as taking up and responding to the patient’s symptom description, as the blood test does after all target inflammation. But this “so” could also be heard to be resuming the physician’s prior talk (Gardner 2007; Hutchby 2020), which is underscored by the fact that the turn is pursuing response to what the physician said *before* the patient added this symptom description. Moreover, by initiating this in repeated interjacent overlap (Jefferson 1984d), the physician rather forcefully takes the floor and works to prevent the patient from adding further diagnosis resistance. By dropping out and restarting multiple times, he treats the *patient* as preventing *him* from returning to his course of action, casting the patient’s ongoing contributions as problematic (Schegloff 2000b; Jefferson 1984d). That he stays his course to complete his pursuit of patient acceptance in lines 15-16 following the patient’s more specific “like... again... my eyeballs” makes particularly salient the effect his turn has for brushing off the patient’s move back to information-gathering activities.

The patient accepts the recommended blood test with “yeah” in line 17, but then continues describing her eye inflammation in lines 19-20 with “like the eye situation doesn’t usually happen... like I started getting it at twenty-one?” This additional symptom description is not only even more specific than the previous, but it prefaces a whole new symptom narrative. The patient thus treats the physician’s prior responses to her symptom descriptions as insufficient and pursues response by

even more overtly making a bid to return to information-gathering activities and return to an activity context where the physician's assessment may still be shaped. Indeed, this kind of persistence almost always follows ignored resistance, except for the few cases where physicians are able to close the activity and move on or close the visit entirely.

b. Minimal Acknowledgments

The next most dismissive type of response to diagnosis resistance is a minimal acknowledgment. The most minimal of these are acknowledgment tokens like *mm hm/ uh huh, yeah* and *okay*, and *hm*, which acknowledge that the patient has taken a turn, but do nothing else. The following extract illustrates this.

In Extract 2 the physician uses “mm hm” and “yeah” to minimally acknowledge two back-to-back instances of patient resistance. The visit began as a follow-up for chronic health problems. Early on in the visit the patient brings up back pain, which he says was recently x-rayed. He adds, as his reason for bringing up this pain, a request for “a back brace or something” (not shown). In response the physician pulls up his x-ray report and, in lines 1-6, discusses the findings – that he has some “degenerative changes between the lower lumbar disc and the sacral disc,” but that it’s a “good thing there’s like no fracture or anything like that.” The patient does not take up this diagnostic talk, and the physician moves to treatment, returning to the patient’s request for a back brace by pursuing more information about what he wants with “so you’re thinking basically something to help you with posture? Like a back brace like that,” in lines 8-11.

(2) AMH 04-15 Diagnostic assessment into counseling

1 DOC: So basically: y'know it does show that there is
2 (0.8) som:e (0.5) degenerative changes betwee:n
3 y'know the lower: lumbar: (0.5) [u:h disc and es-
4 PAT: [Mm hm,
5 DOC: the sacral disc, (0.2) u:m (0.2) good thing
6 there's like no fracture or anything like that.
7 (0.8)

8 DOC: .t So: (0.8) u:m you're thinking: basically
9 something to help you with posture? like a:
10 PAT: Yeah.
11 DOC: Like a back brace like tha:t,
12 PAT: -> I mean I can't ho- I can't- I get pai:n (1.0)
13 -> from standing up.
14 DOC: Mm hm: ,
15 PAT: -> (And) es- especially in my: (1.2) my b- (0.2) butt
16 -> an:d hamstring muscles.
17 DOC: Yeah.
18 (1.0) ((DOC typing on computer))
19 PAT: I don't know if it ma:y (0.2) related to the back.
20 (1.0)
21 DOC: Remind me have we ever: um (0.2) talked about
22 (0.2) having you see physical therapy,

The patient agrees with “yeah” in line 10 but then adds “I mean I can’t- I get pain from standing up” in lines 12-13. The “I-mean” preface of this marks the patient’s turn as *not* an answer to this question, but rather an unpacking of the patient’s own prior talk during the problem presentation (Maynard 2013). As a new symptom description, the turn further invites a return to information-gathering – which, notably, the physician did none of because this problem was not initially presented as a new one. The physician treats this as neither a complete answer to her question *nor* a turn resisting her move to treatment. Instead, she says “mm hm,” which acknowledges the patient’s turn but, as a continuer, neglects to take the floor, treating the patient as unfinished and his action as not recognizably complete (Schegloff 1982).

In lines 15-16 the patient aligns with this orientation by continuing, adding another symptom description built as an increment to his first turn with “and especially in my butt and hamstring muscles.” The disfluency in this turn may indicate that the patient, who was designedly finished with his turn at the end of line 13, is prompted to say more by the physician’s continuer “mm hm.” This additional symptom description again invites reassessment by presenting entirely new information – that the pain is not in the patient’s back *per se*, but also down into his legs. This is potentially inconsistent with a problem treatable by a back brace for posture and suggests that the patient may have used his request as a way to re-introduce a presumably already-resolved health problem.

In response, the physician minimally acknowledges the patient's turn with a falling-intoned "yeah" in line 17. Unlike rising-intoned minimal acknowledgments, falling-intoned ones do not overtly treat the patient as unfinished. And whereas *mm hm/ uh huh* has been shown to lean toward an interpretation of the patient as unfinished (Schegloff 1982), and *okay* toward an interpretation of the patient as finished (Schegloff 2007), *yeah* – which is by far the most common minimal acknowledgment following diagnosis resistance – is agnostic as to the completeness of the patient's talk. Moreover, *yeah* is notably uncommon during the problem presentation, where you're more likely to see *mm hm/ uh huh* and *okay* (Heritage & Clayman 2010). *Yeah* is more reminiscent of everyday talk, where a listener might "just" listen, rather than listen as part of a project to diagnose or treat (Jefferson & Lee 1981), and is often used as the most minimal way to acknowledge a turn before a speaker comes in to move on to something else (Jefferson 1993).

In this case (as in many), after no further response from the physician, the patient continues in line 19 with "I don't know if it may ... related to the back." By stating something in the physician's domain of expertise, and prefacing it with "I don't know," the patient pursues response and upgrades his ongoing resistance by more explicitly requesting further assessment of his problem (Park 2012). This ultimately treats the physician's minimal acknowledgment as unsatisfactory – it was not enough for the physician to merely acknowledge the information he has shared; she was supposed to *do* something with it.

Minimal acknowledgments of diagnosis resistance also include collaborative completions, which go further to display rather than merely claim understanding (Heritage 1984b; Schegloff 1982, 2007; Lerner 2004) but still without treating the turn as resistant. In sum, minimal acknowledgments brush off patient resistance by acknowledging that the patient has taken a turn but doing nothing else to respond to it. As a result, these responses make no display of the physician's interpretation of the patient's turn as resistant or otherwise, and interactionally bypass – if only temporarily in the

case of persistent resistance – the patient’s invitation, however subtly conveyed, to reconsider their assessment of the patient’s problem.

c. Treating Patients’ Turns as Non-Resistant

The remaining actions in this category are more substantive second-position responses to diagnosis resistance. Unlike ignoring the patient’s turn or minimally acknowledging it, these responses display an understanding of the patient’s turn *as* response relevant. Nonetheless, they brush off the patient’s resistance by treating the turn as non-resistant. In this section I examine a small variety of ways physicians do this, each of which displays a slightly different alternative understanding of the import of the patient’s turn: setting the patient’s turn aside from the clinical agenda through empathic responses and dismissive displays of uncertainty, bidding for closure through optimistic projections, and explaining away the symptoms.

The first way physicians treat a patient’s turn as non-resistant is through empathic responses. These are actions characteristic not of medical institutional talk, but of everyday talk. By responding to a patient’s resistant turn in this way, physicians cast the sequence as an aside from the ongoing activity of medically solving the patient’s problem, bypassing the threat the patient’s turn may have posed to the physician’s diagnostic assessment. Consider Extract 3.

In this visit the patient has presented with elbow pain, which the physician diagnosed as bursitis due to a flare-up of gout, a chronic arthritic condition the patient has been living with for a few years. After the diagnosis the physician initiates a discussion about how to better control the gout and has pointed out that if the patient hadn’t missed a week or more of his medication (due to issues with his pharmacy) he would not have had this flare-up. During that conversation, the patient points out that his flare-ups do not line up with his history of taking his medication, resisting the diagnosis by suggesting that his pain may be due to something other than gout.

As the extract opens the patient is coming to the end of another extended telling about the

series of flare-ups he’s been having recently, ending with “so I’m just like” and a palms-up gesture conveying not-knowing and possible exasperation with his symptoms. On one hand this gesture pragmatically completes the turn by gesturally demonstrating the feeling or behavior referred to by “I’m just like...” Indeed, the physician treats the patient’s turn as finished by taking up and responding to the gesture with “we gotta get this in control” in lines 2-3, which treats the patient’s turn as a treatment-relevant complaint about his gout. But the patient has not verbally brought his turn to a close, and he uses this ambiguous transition space to re-take the floor and initiate another symptom description/ complaint with “and I’m not doing a lot too” in line 4. He then cuts himself off to respond to the physician with “exactly” and then, with the ensuing “so,” returns to what he was saying (Gardner 2007; Hutchby 2020) to add a new symptom description. This is the focal instance of resistance.

(3) AMH 02-06 Counseling

((PAT completing prior resistant turn))
 1 PAT: Yea:h so I'm just like ((palms up)) [I can't-
 2 DOC: [We gotta get
 3 thi[s in control.
 4 PAT: -> [and I'm not doing (a lot too:)=Exactly. So
 5 -> I'm not even:<if I was to say (I was going) from a:
 6 -> one to a ten,
 7 (0.2)
 8 PAT: -> In terms of ability:,
 9 DOC: Ye[ah.
 10 PAT: -> [>physical ability,< I'm only like (0.8) pushing
 11 -> myself to a five.
 12 (0.2)
 13 DOC: Yea:h that['s-
 14 PAT: -> [When these things are happening.=[So it's:
15 DOC: [That's
16 terrible.
 17 PAT: Yea:h. It's frustrating.
 18 DOC: So we need to do something about it.

In lines 5-11 the patient, who is an athlete, describes how his “physical ability” has been impacted, saying that he’s “only like pushing myself to a five” out of ten. The physician begins to respond to this in line 13 with “Yeah that’s–” but the patient comes in in overlap to add “when these things are happening” in line 14. This increment is important in terms of the patient’s project,

because it links this symptom to others he has been working to cast as potentially due to something other than his gout. It is in response to this that the physician does an empathic response with “That’s terrible” in lines 15-16, orienting to the patient’s turn as nothing more than additional complaining. This turn is hearably a return to what the physician was going to say in line 13 with “yeah that’s-” and treats the patient’s increment as irrelevant in shaping his response. Because this turn does nothing more than negatively assess the patient’s suffering, it is wholly occupied with displaying empathy for the patient’s situation.

While acknowledging the patient’s illness experience is seen as beneficial for the physician-patient relationship (e.g., Frampton, Guastello & Lepore 2013), in this context it simultaneously declines to acknowledge the potential clinical significance of the patient’s complaint, nor any potential concerns underlying the complaint. Such empathic responses are available as resources for responding to troubles talk in everyday – i.e., non-medical – settings. But in a medical setting, they move away from the affective neutrality characteristic of institutional talk (Parsons 1951; Heritage & Clayman 2010). Indeed, as visits move toward closing, physicians and patients do often begin to engage in more everyday-like talk, chatting for example about their personal lives, the weather, sports, etc. But by casting the patient’s turn as more like that kind of talk, empathic responses set the turn aside, treating the issue as sympathizable-with rather than actionable (Jefferson & Lee 1981) while the patient may still be trying to affect the clinical agenda.

In line 17 the patient agrees with the physician’s assessment with “yeah,” adding “it’s frustrating.” This addition is hearably a return to what the patient was going to say with “So it’s:” in line 14. By agreeing with the physician’s assessment but marking it as something he was already going to say, the patient claims ownership over the sequence and its content (Lerner 2004). He also renews the complaint and creates a new slot in which the physician should respond. Moreover, by changing “terrible” to “frustrating,” the patient moves from an assessment casting his complaint as

merely seeking acknowledgment of a bad experience to one seeking a solution to an experience that is upsetting because of the patient's inability to change it.

The physician indeed takes up this meaning by stating that "we need to do something about it" in line 18. By responding to the patient's complaint with a move toward a remedy, this response marks a return to institutional talk. However, it is an observable return to what the physician was doing in lines 2-3 with "we gotta get this under control." By returning to the course of action initiated before this complaint, the physician treats the complaint as merely an extension of the patient's prior complaint. However, the fact that the patient added this new complaint in the first place has marked the physician's response to the prior one as insufficient. Indeed, the patient continues to resist the physician's diagnosis of a gout flare-up to the point where, later in the visit, the physician engages with the patient's concerns by discussing the possibility that the patient has more than one type of arthritis.

Another way physicians display an understanding of patients' turns as non-resistant is through dismissive displays of uncertainty, as illustrated in Extract 4. In this visit the patient has presented with pain and bruising on his foot, but without any obvious injury he can recall. The physician has recommended an x-ray to check for a fracture, but the patient has repeatedly suggested that it could be an insect or spider bite. Before the beginning of the excerpt the physician has been typing on the computer, placing an order for the x-ray and entering information in the patient's chart. During the corresponding lull in the conversation, the patient has been repeatedly adding increments of new information about his symptoms. This is what he's doing in lines 1-2, when he adds that, when he's at home, he normally wears Crocs, which are foam resin slip-on comfort shoes with ventilation holes. The physician responds with a rising-intoned "okay" in line 4, treating the patient as unfinished.

The patient produces a single laugh token in line 5, displaying his prior turn as finished and

orienting to it as potential trouble (Jefferson 1984a). By revealing that he sees the new information he's volunteered as potentially problematic, he simultaneously takes an "innocent" reading of his turn off the table (Goffman 1978) and exposes an underlying agenda. Although he doesn't reveal what the agenda *is*, in this clinical context the locally relevant reading is diagnosis resistance. The physician acknowledges the completeness of the patient's turn with a falling-intoned "okay" in line 6, and a "hm" in line 8.

The patient then unpacks his prior comment in terms of its relevance for the diagnosis with "so something could've sneaked down in the crock" in lines 10-11, adding "it's got those little holes" in line 13. By adding this explanation, the patient treats the physician's unelaborated "hm" as evidence that she did not grasp the import of his original utterance.

(4) AMH 05-05 Counseling

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          ((DOC typing on computer))
1  PAT:   I normally wear: when I'm at ho:me I normally
2         wear=uh (1.0) crocs.
3         (0.2)
4  DOC:   Okay,
5  PAT:   °Ha°
6  DOC:   Okay.
7         (0.5)
8  DOC:   Hm.
9         (2.0) ((DOC typing again))
10 PAT:  -> So something could've sneaked down i- in the
11        -> crock.
12        (0.5) ((DOC shifts gaze to PAT))
13 PAT:  -> It's got [those little holes.
14 DOC:           [(      ) It has little holes.=[You never
15 PAT:           [( (laughs)
16 DOC:   know.
17         (0.5) ((DOC retuning to computer))
18 DOC:   And no:w (0.5) I'm gonna actually have them come in
19        here and just check your INR too,
```

The physician stops typing and looks up at the patient without responding in line 12, prompting the patient to further unpack his turn with "it's got those little holes," in reference to the Crocs. This expansion treats the physician's lack of substantive response until now as a matter of understanding. The physician collaboratively completes this expansion (Lerner 2004) with "it has

little holes” in line 14, and then rushes through to add a dismissive display of uncertainty with “You never know” in lines 14-16.

On its face, “you never know” acknowledges the possibility that the patient’s candidate explanation, and by extension his candidate diagnosis of a bug bite, is correct. At the same time, it’s a truism, adding nothing new clinically, declining to acknowledge or engage with the resistance embodied in the patient’s turn, and bidding for closure (Drew & Holt 1995, 1998). Like empathic responses, truisms are not characteristic of institutional talk, especially in a medical setting. Imagine, for instance, a physician doing a dismissive acknowledgment of uncertainty in response to a candidate diagnosis like “my wife was worried it was a kidney infection,” produced as part of a problem presentation; this would be highly uncharacteristic of talk in a medical encounter. Dismissive displays of uncertainty set the patient’s turn aside from the primary clinical agenda and brush off patient concerns underlying his diagnosis resistance.

In lines 17-19 the physician returns to her prior course of action by turning to her computer and adding that she will order a test of the patient’s INR, which checks the levels of the patient’s blood thinner. This actually *is* potentially related to the patient’s foot problem, although the physician does not connect them explicitly, because a high INR could lead to the kinds of unexplained bruising the patient is experiencing in his foot. By turning toward the computer and initiating her turn with “now,” the physician is observably closing the prior course of action and moving toward a new one. This new course of action is notably a return to clinical talk and is driven by the physician’s own agenda. Taken together, these features underscore the contrast between her clinical agenda and the patient-initiated prior sequences, and further cast her dismissive display of uncertainty as an attempt to set those sequences aside from the official institutional agenda.

Another way physicians display an understanding of a patient’s turn as non-resistant is through what Jefferson (1988) calls optimistic projections like “it’ll get better,” “we’ll get you taken

care of” and, as Extract 5 illustrates, “we’ll get to the bottom of it.” This extract revisits the patient from Extract 1, who has presented with multiple problems, one of which is a burning sensation in her hands and feet. The physician recommended blood tests “to make sure there isn’t something else going on, like something inflammatory or something related to vascular issue” (not shown here) but added “which I don’t think is the case.” Later the patient revealed a concern about arthritis, which the physician explicitly ruled out.

At the beginning of the extract here the physician and patient are discussing plans for a follow-up visit. As part of an account for suggesting a follow-up, the physician comments on “all the different symptoms you have” in lines 1-2. Through complaints and embodied behavior, the patient has throughout the visit displayed a stance toward her symptoms as excessive to the point of absurdity, and emphatically agrees with the physician’s comment with an elongated and creaky “yeah” in line 3. The physician immediately re-completes his turn with “so d- I think it’s best to come in” in line 4, ending on the topic of the follow-up visit and making *that* the focal and response-relevant topic, rather than the patient’s variety of symptoms (Schegloff 2007).

(5) AMH 02-18 Counseling

((Discussing follow-up visit))
 1 DOC: We'll probably have things to talk about because of
 2 all the (.) .h different symptoms you ha:ve,
 3 PAT: #Y:ea[:h.#
 4 DOC: [So d- I think it's best to [come in.
 5 PAT: [I come across
 6 as like a wreck. >It's just like<
 7 DOC: ((laughs)) Y(h)eah. [.h
 8 PAT: -> [Like right no:w it's just
 9 -> like it's kind of burning in here and it's just
 10 -> like (.) ahhh ((gesturing toward forearms))
 11 DOC: Yea::h.
 12 (0.2)
 13 **DOC: Yeah I know it is='n so um (0.8) so we'll get**
 14 **to the bottom of [it. Okay?**
 15 PAT: [Great. So am I doing the blood
 16 test today too?
 17 DOC: Yeah.

Before the physician completes this increment, the patient comes in in interjacent overlap

(Jefferson 1984d) to expand her response to his comment about her symptoms, renewing her earlier stance with a self-deprecating “I come across as like a wreck.” She then adds a quick “It’s just like” in line 6, but leaves “what it’s like” unstated. The physician takes this up with laugh particles and a laughter-infused “yeah” in line 7, affiliating with the patient’s ongoing stance toward her symptoms as laughable. He then does an in-breath indicating further talk, which is likely going to move on from this sequence, given the falling intonation on the “yeah” and the clear separation of that turn from whatever is coming next.

In overlap with this in-breath the patient adds what Heath (2002) calls an “opportunistic revelation” of suffering, which he says “exploits” the patient’s ostensible experience of an internal feeling in an attempt to “encourage the doctor to adopt an ‘investigative or diagnostic’ stance” toward their symptoms (Heath 2002:603-4), i.e., to return to an activity context where the physician’s assessment may still be shaped. The physician takes this up with two “yeahs” in line 11 and then “yeah I know it is” in line 13, treating the information as known and thus not clinically informative. He then adds “so we’ll get to the bottom of it, okay?” in lines 13-14.

Jefferson (1988) calls utterances like these ‘optimistic projections,’ a method participants use to exit troubles telling sequences in everyday talk. Optimistic projections tend to be generalized rather than granular, are distinct from and often subsequent to actual suggestions for resolving the trouble and are closure relevant. Although optimistic projections acknowledge patient concerns, they merely provide reassurance rather than new clinical suggestions or consideration of the patient’s problem. They thus neither acknowledge nor engage with the diagnosis resistance embodied in the patient’s turn and brush off patient concerns. Moreover, unlike other types of brush-offs, optimistic projections explicitly bid for closure of the resistance sequence, which is underscored in this case by the physician’s acceptance-pursuing, rising-intoned “okay?” in line 14. The patient aligns with this move to exit with “great,” in line 15, and a logistical question about her blood tests in lines 15-16.

The final extract shows a physician displaying an understanding of a patient's turn as non-resistant by explaining away the symptom the patient presented in her resistant turn. In this case the patient presented with a painful lump in her side, which her obstetrician suggested is scar tissue from a c-section, but which the patient is worried is a hernia. The physician has not diagnosed the problem, instead acknowledging that it's unclear whether it's scar tissue or a hernia and recommending a CAT scan to find out. Despite this test recommendation, the patient has persistently questioned and volunteered new and repeated symptoms. It never is made clear what might be driving the patient's persistent resistance, but this kind of continued problem description is common in contexts of explicit uncertainty.

Toward the end of the visit, after extended talk about a separate problem and while the physician is entering orders on the computer, the patient does an opportunistic revelation in the beginning of the extract below. She stands up, begins rubbing the painful area, and says "right now it's like pulsating" in lines 1-2. Her use of the locally subsequent reference term "it's" creates some ambiguity as to whether she is connecting this problem to the just-prior discussion about inflammation (see Extracts 1 and 5), or tying back to the earlier discussion about her scar tissue. In any case, she rushes through to add "I dunno if that-" in lines 1-2. By cutting herself off before completing her question, the patient again leaves ambiguous exactly what she is getting at with her resistance; nonetheless, having produced the first part of her question at all pursues uptake and comment on the relevance of the symptom to the ongoing clinical project. Instead, the physician responds by explaining away the symptom in line 4, "It's 'cause I had you push so hard" – referring to the physical examination.

(6) AMH 02-18 Counseling

```
1 PAT: -> (S-) (0.2) Right now it's like pulsating:=I dunno
2         -> if that-
3         (0.2)
4 DOC:   It's 'cause I had you push [so hard.
5 PAT:                                       [O::h.=hh Alright.
```


6 (0.2)
7 DOC: Sorry it's really uncomfortable,
8 PAT: No:,=hh
9 (0.2)
10 PAT: It's- it's not horrible it's just (1.5) there
11 and unpleasant. Let's put it that way. .hh
12 (0.2)
13 PAT: It's livable.
14 (.)
15 PAT: °But°
16 (45.0) ((DOC on computer))

By responding to her symptom description in a way that explains it away and by locating the cause of the pain in the physical examination rather than any underlying characteristic of the health concern, the physician neutralizes whatever threat the symptom may have presented to his earlier diagnostic assessment. He thus preserves that assessment, but without actually acknowledging any threats to it or engaging with the patient's concerns underlying the symptom presentation. Indeed, by explaining the patient's symptom, he treats the description itself, and the elided question following it, as motivated by a desire for understanding, rather than a desire to influence the diagnostic assessment.

The patient aligns with the physician's orientation with a change of state "oh" (Heritage 1984b) and accepting "alright" in line 5. The physician then adds an empathic response with "sorry it's really uncomfortable" in line 7. This apology continues his project to cast the patient's pain as related to his own actions in the physical exam. The patient affiliates by rejecting the need for apology with "no" in line 8, and then re-casts her pain as "not horrible" but rather just "there and unpleasant" in lines 10-11, adding that "it's livable" in line 13. Although on one hand this description could hearably be continuing to refer to the pulsating that the physician attributed to the physical exam, by describing it as "there" but "livable," the patient expands the referent to potentially encompass her daily experience with the pain complaint itself. In any case, by displaying troubles resistance in response to the physician's apology, the patient eases up on her diagnosis resistance before trailing off with a quiet "but" in line 16, followed by an extensive lull as the

physician continues entering orders on the computer.

d. Summary

Table 1 shows the distribution of the subtypes of brush-offs in the data.

Table 1
Distribution of brush off responses

Response type	<i>Frequency</i>	<i>Percent</i>
Minimal acknowledgment	50	50%
Substantive brush off	39	39%
Ignore	12	12%
Total	101	101%

Note: percentage totals subject to rounding effects

Nearly half of brush-offs are minimal acknowledgments, and a further 39% are made up of the more substantive brush-offs displaying an understanding of a patient's turn as non-resistant. Only 12% are comprise ignoring what the patient said. What these somewhat disparate responses have in common is that physicians neither acknowledge nor engage with the patient's resistance *as* resistance. It's important to note that, as shown in the extracts in this section, brush-off responses are typically, though not always, produced in response to the least overt types of patient resistance. Thus actions that don't look like resistance are not, in these cases, being treated as resistance. The relationship between resistance type and response type will be addressed in more depth later in this chapter, when I examine the frequencies, distributions and patterning of response types in the data.

When they brush off patient resistance, physicians interactionally bypass the threat the patient's turn may have posed to the physician's assessment, and the invitation, however subtle, to reverse the visit's progressivity to an activity context where the physician's assessment may still be shaped. As a result, these responses avoid having to cede (or reassert) epistemic authority over diagnostic inquiry, and typically afford the fastest return to the physician's interactional agenda. In

the following sections I illustrate the two broad ways physicians respond when they *do* acknowledge a patient's resistance: physician-centered and patient-centered responses.

3.4.1.2 Overview of Responses Oriented to Resistance

The physician responses illustrated in these next two sections differ from those in the previous section in that physicians *do* acknowledge resistance, either by pushing back against it or to varying degrees aligning with the patient's invitation to return to information-gathering and/or reassessment. Together, all responses in this category make up just under half of the cases in the dataset (see Table 5). As I will discuss in a later section looking more closely at the distributions of physician responses across interactional contexts, nearly half of the responses in this category occur in the context of more off-record types of resistance like symptom descriptions, and the other half in the context of more upgraded types of resistance like candidate diagnoses, questions about symptoms, and requests for further diagnosis or testing.

Physician responses that go on record to acknowledge patient resistance are divided into two groups: physician-centered responses that observably work to move past the resistance and return to the physician's agenda as quickly as possible, and patient-centered responses that put the physician's agenda on hold and work more expansively to acknowledge or address patient concerns before moving on. A cluster of turn design features characterize the distinction between these types of responses, which are distilled in Table 2 and described below. Few if any responses are characterized by *all* of the features in one category versus another. But viewed from the perspective of ideal types, these feature clusters set the categories apart in a theoretical way and help unpack what is so distinct between the two when they emerge in the data.

Physician-centered responses tend to be minimal, i.e., one unit or turn, and to be sequentially closure-relevant, whereas patient-centered responses tend to be more expansive, i.e., multi-unit or multi-turn packages that are sequentially expansive. Relatedly, physician-centered responses tend to

obscure a slot for patient response or at minimum treat patient response as irrelevant, whereas patient-centered responses tend to pursue patient uptake, acceptance, or displays of understanding.

Table 2
 Characteristics of physician-centered vs patient-centered responses to resistance

Physician-Centered	Patient-Centered
<i>Single unit/ turn</i>	<i>Multi-unit/ turn</i>
<i>Sequentially closure-relevant</i>	<i>Sequentially expansive</i>
<i>No pursuit of patient uptake</i>	<i>Pursuit of patient uptake</i>
<i>Embodied orientation toward competing or next activity</i>	<i>Embodied orientation toward patient & current talk</i>
<i>Speech fast and/ or quiet</i>	<i>Measured cadence of speech</i>
<i>No or little mutual gaze</i>	<i>Mutual gaze maintained</i>
<i>No or nominal explanation</i>	<i>Extensive explanation</i>

In terms of embodied behavior, physician-centered responses are often produced as the physician is observably engaged in or moving toward some competing or next course of action, e.g., scrolling through documents on the computer, fetching some medical equipment or supplies, leaving the room, etc. The physician’s speech is often fast and/or quiet, and mutual gaze is rarely established. In contrast, during patient-centered responses physicians more often pause what they are doing to face and gaze at the patient, speak in a more measured cadence with pauses at the ends of units, and elaborate their talk with iconic gestures or even diagrams or other images.

Finally, in terms of content, physician-centered responses are typically unelaborated and, when a physician *does* account for or explain a diagnosis, any attempt at persuasion is nominal at best and does more to reassert medical authority than to bridge the gap between patient and physician perspectives. In contrast, patient-centered responses typically involve somewhat extensive explanation of the diagnosis or its etiology, uncertainty related to the diagnosis, or the evidential basis for the diagnostic assessment.

In the following analyses I illustrate some of the recognizable and recurring forms each of these types of responses take in the data.

3.4.1.3 Physician-Centered Responses

a. Obscuring Disagreement

The first subtype of physician-centered responses shares some features with brush-offs: although physicians *do* acknowledge and engage with patient resistance by pushing back, they do so in a way that obscures explicit disagreement or disalignment with the patient's bid to return to information-gathering and/or reassessment. These responses typically involve reassertions that designedly incorporate the patient's turn, or that are elided entirely. Reassertions of the diagnosis are indeed the strongest and most authoritative way a physician can push back against diagnosis resistance. As will become evident, reassertions, and to a lesser extent other types of disagreeing or disaligning responses, are often accompanied by epistemic downgrades, accounts, and explanations. But when a reassertion incorporates the patient's contribution or is obscured altogether, such interactional work is not present. This is what makes these responses somewhat similar to those that brush off the resistance entirely – by disagreeing without doing so overtly, physicians avoid the time and authority cost of persuasion. In this section I show three ways physicians disagree without doing so overtly, each of which draws on different interactional resources: returning briefly to history-taking and then moving on without comment; eliding the reassertion altogether through self-repair and restart; and incorporating the patient's turn into the reassertion.

The first way physicians disagree without doing so overtly is by returning to history-taking and then moving on without comment. Returning to history-taking is, on its face, an aligning move following diagnosis resistance, which by definition invites a move back to information-gathering and thus reassessment of the patient's problem. But in this response category, physicians obscure the slot where reassessment would be relevant, instead using it as a way to pivot back toward their own

agenda. Extract 7 illustrates this.

In this visit the patient presented with coughing, wheezing and pressure in his ear. During history-taking he mentioned that he thinks he's getting an ear infection. In lines 1-4 of the extract, the physician diagnoses him instead with a sinus infection. Facing the patient, he then begins to explain the diagnosis, saying "you got a lot of fullness in the nose" and "that's your first line of defense." In lines 5-6 the patient resists with a symptom description "I've been stuffed up for a long time," which pushes back against the physician's implication that he's in the early stages of his illness and may support his own theory that the problem has gone beyond his nose/ sinuses and into his ears. The physician acknowledges this with two "yeahs" in lines 7 and 8, and momentarily continues his explanation by tying the patient's cough to the sinus infection diagnosis. On one hand, this could potentially be heard as a response to the patient's resistance, as it does more work to convince via explanation. However, it could also be heard as a continuation of the physician's post-diagnosis explanation, which was already doing this work.

(7) AMH 03-04 Diagnosis into counseling

```
((DOC facing PAT to deliver Dx))
1  DOC:  .h So >I think< you got a little sinus infection,=
2        You got a lot of fullness in the no:se. .hh So
3        that's your first line of defense. So as that
4        [stuff comes i:n, (0.2) your body sort of rea:[cts,
5  PAT:  -> [Yeah.                                     [I've
6        -> been stuffed up (0.2) [f- for a l:ong time.
7  DOC:                                     [Yeah.
8  DOC:  Yea:h and then you can get that post-nasal drip. So
9        that's [(in the chest and the cough there.) .hh U:m
10 PAT:  [(causing cough,)
11 DOC:  hh .t a:nd it's been how many:- how many: [weeks
12 PAT:                                     [The n-
13 DOC:  [that you said the stuffiness [and the congestion,
14 PAT:  [the: s-                               [the stuffiness and
15        congestion has been since a week ago Monday at [least.
16 DOC:                                     [Okay.
17        (0.5)
18 DOC:  A::nd (.) did you feel like you were getting better:,
19        then all of a sudden got worse,=[or it just sort of
20 PAT:                                     [No. It's been ge-
21 DOC:  [progressed.
22 PAT:  [It's been getting [worse. It's been getting w(h)orse.
23 DOC:  [$Ohh heh (h)it's:$ ((turns from PAT))
```

24 DOC: And the fires don't [hel:p, ((walks to trashcan))
 25 PAT: [((coughs)) God no.=
 26 DOC: =And the Santa Ana win:ds, you're- you just ca:n't
 27 win this battle [right now. ((walks to hand sanitizer))
 28 PAT: [Yea:h.
 29 DOC: <So [what we'll do= ((turning back to PAT))
 30 PAT: [My kid-
 31 PAT: =My kid's two:=he's in preschoo:l...

In any case, the physician returns to history-taking with “and it’s been how many weeks that you said the stuffiness and congestion” in lines 11-13, still facing the patient. Despite the design of this question, the patient never actually discussed stuffiness and congestion during problem presentation or history-taking. Moreover, the question is framed in terms of “how many weeks,” presupposing that “a long time” is on that time scale, raising the bar for the patient’s complaint and subtly challenging the legitimacy of the patient’s complaint. The patient, however, answers in terms of days rather than weeks, and orients to the threat this presents to the legitimacy of his complaint by adding “at least” in lines 14-15.

The physician takes this up with “okay” in line 16 and a second question “and did you feel like you were getting better, then all of a sudden got worse, or it just sort of progressed” in lines 18-21. Although this is designed as an either-or question, the patient leads with “no” in line 20, selecting and pushing back against the notion that he may have gotten better at some point. He then adds that “it’s been getting worse,” emphasizing this by coming in in overlap with the physician’s not-yet complete question in line 21 and repeating it until he gets it out in the clear in line 22. The final version is also produced with a troubles-resistant laugh token (Jefferson 1984a), doing further work to emphasize the severity of the problem.

The physician builds on the patient’s response by adding “and the fires don’t help” in line 24. That this turn affiliates with the patient’s is further evidenced by the smile-voiced “oh” and laughter preceding the turn in line 23, which pick up on the patient’s own laugh token. But the physician’s turn does not *align* with the ongoing project to renew assessment of the patient’s problem (Stivers

2008), which was initiated by the patient's resistance and pursued by the physician's return to history-taking. Indeed, this empathic affiliation occupies the slot where the physician could have relevantly revised, reasserted, or more generally commented on his diagnostic assessment. A contrasting case, where a physician *does* comment on the diagnosis following a return to history-taking, can be found in the patient-centered responses below. In the present case, the physician never returns to the diagnosis, nor to further history-taking.

Moreover, although the physician was facing the patient during the diagnosis delivery and into his return to history-taking, at the point where he moved into everyday banter rather than a reassessment, he began turning away from the patient in line 23. Over the course of the following lines, he engages in the transition-relevant activity of throwing away the gloves he wore for the physical exam and cleaning his hands with hand sanitizer. It is only when he's about to move on to treatment in line 29 that the physician moves to re-establish gaze with the patient, although this happens to be cut off by what will be ultimately become another instance of diagnosis resistance – a mention that the patient's two-year-old had an ear infection. The physician's embodied behavior here does additional work to reinforce the elision of a sequentially relevant reassessment of the patient's problem, and to display a pivot back to the physician's agenda and the normative activity structure of the visit.

By returning to history-taking the physician takes up the potential clinical relevance of the patient's contribution. But it is worth pointing out that both of the physician's history-taking questions target symptoms that would further support his sinusitis diagnosis, and no response – at least among the constrained choices presented by the questions – would have suggested an alternate diagnosis. Thus, although the information sought has clinical relevance, it would not have changed the diagnosis. This suggests that return to history-taking was *pro forma*, and the questions were interactionally, rather than clinically, motivated. In other words, they were done to appease the

patient, who displayed a desire to get this information “on the table” (McArthur 2018). Although an implicit reassertion of the original diagnosis can be inferred from the clinical and interactional context, by moving on without comment the physician manages to avoid the slot where reassertion might relevantly happen. In this way, the physician pushes back against the patient’s diagnosis resistance while on the surface aligning with it, avoiding the time and authority cost of persuading the patient.

A second way physicians push back against diagnosis resistance without overtly disagreeing is by eliding the reassertion. Unlike a return to history-taking, reassertions by their very nature disalign with the patient’s project, but in these cases, physicians cut themselves off before actually reasserting the diagnosis. But rather than restarting a new action trajectory as though, for example, they’ve decided a reassertion is *not* the way they want to go, physicians move on in a way that aligns with a reassertion having occurred. This is what gives the reassertion the air of having been elided rather than erased. Consider Extract 8.

In this visit the patient presented with dryness in her mouth, which the physician diagnosed as thrush – a fungal infection in the mouth – from the use of an inhaled steroid. During her problem presentation, the patient mentioned that her dentist thought she had geographic tongue, which involves the loss of some of the tiny hairs coating the tongue, leaving patches that can look like a map. In line 1, the physician recommends Nystatin, a treatment for thrush. The patient accepts the treatment with two “okays” in line 3, and then returns to the diagnosis by adding “oh my gosh.” The physician responds with “I mean that’s not,” potentially beginning to reassure her that this isn’t a serious condition, but cuts himself off when she adds, unpacking her “oh my gosh” in interjacent overlap, “so you don’t think it’s geographic tongue” in lines 6-7. The physician’s response in line 9 – “probably not, geographic tongue doesn’t hurt” – is a neutralizing response with perfunctory persuasion, which will be described in the section below. After 1.5 seconds of silence the patient

accepts with “okay” in line 11, but in “blind spot” overlap (Jefferson 1986) the physician pursues response with an increment in line 12 “it just looks weird.” In fact, the patient did not mention pain on her tongue during her problem presentation, and so the physician’s reference to that symptom as support for his diagnosis is somewhat misplaced.

(8) AMH 02-11 Counseling

1 DOC: So I'll just give you some Nystatin and (0.5)
2 take care of it.
3 PAT: Oka:y. Oka:y. Oh my gosh.
4 (0.8)
5 DOC: W- >I mean< [that's not-
6 PAT: [S'you don't thi- you don't think it's
7 geographic tongue.
8 (0.8)
9 DOC: Probably no:t.=Geographic tongue doesn't hurt.
10 (1.5)
11 PAT: Ok[ay.
12 DOC: [It just looks weird.
13 PAT: -> Yeah >it's probably-< 'cause I felt like my s-
14 -> like I (didn't)- like I feel like- did I- I don't
15 -> remember eating hot food.
16 DOC: **No: I think it's probably- again- make sure you're**
17 **rinsing your mouth ou[t,**
18 PAT: [I d- I a:m!

The patient minimally takes this up with “yeah” and then adds “I don’t remember eating hot food,” which is produced after extensive cut-offs and restarts. What this turn is doing is somewhat ambiguous. On one hand, stating that she doesn’t remember eating hot food suggests that the patient’s tongue *does* hurt, which would support the physician’s diagnosis but without calling the physician out for having asserted pain without the patient having done so first. On the other hand, it proffers another cause for the patient’s complaint – eating hot food – and thus, however mildly, challenges the diagnosis by inviting a return to diagnostic assessment. In response, the physician produces an elided reassertion with “no I think it’s probably- again- make sure you’re rinsing your mouth out” in lines 16-17.

There are a few noteworthy turn design features here that reveal an elided reassertion. First, the turn-initial “no” marks the coming turn as something in agreement with the patient, but

simultaneously rules out the implicit suggestion of hot food as a potential cause of the patient's problem (Jefferson 2002). Then, "I think it's probably..." not only mirrors a common formulation for diagnostic utterances, it also recycles the "probably" the physician used in his original diagnosis (not shown) and in his rule out of geographic tongue in line 9 ("probably not"). The physician then cuts off this utterance and restarts with "again," which is itself cut off. This "again" is ambiguous in terms of whether it's beginning a diagnosis reassertion, but notably, the treatment recommendation he ends up producing after it (to rinse her mouth out) is *not* a repeated recommendation. It follows, though, from a diagnosis of thrush due to use of an inhaled steroid. The restarted turn thus builds on, rather than replaces, the reassertion he never fully produced, and the "again" acts as a link between the two.

Elided reassertions are fascinating interactional accomplishments, which are made possible by the affordances of restarts. That is, when we restart a turn, we've accountably decided *not* to produce the cut-off turn, and whatever we produce afterward hearably replaces it. However, the cut-off turn has been produced and heard; conversation analysts have focused on the hearability of the cut-off turn as a resource for analysts (Drew, Walker & Ogden 2013), but it is also a resource for recipients, who could for example call someone out for what they were "going" to say (Jefferson 1974). I suggest that restarts are also resources for speakers: that a cut-off turn is interactionally but not actually deleted allows speakers to almost-produce – and thus convey the sentiment of – potentially problematic actions like disagreements without actually going on record with the disagreement itself. And despite the seeming rarity with which such a subtle yet complex interactional accomplishment might occur, there are actually 6 elided reassertions in the data, making this a distinct practice rather than a one-off, ad hoc accomplishment.

A final way physicians push back against diagnosis resistance without overtly disagreeing is by incorporating a patient's resistant turn into a reassertion of the original assessment, avoiding

overt disagreement. These responses occur fairly regularly, although they are afforded by a restricted set of clinico-interactive contexts. For example, if a patient's candidate diagnosis is not mutually exclusive from a physician's, the physician can acknowledge the patient's hypothesis as an additional possibility, before re-asserting their original assessment and continuing on with their agenda.

Another frequent context where physicians incorporate a patient's resistant turn into a reassertion is when they have explicitly cast the diagnosis as uncertain, and the diagnostic assessment for the current visit is not a definitive diagnosis *per se*, but rather a determination that a specific test or referral to a specialist is necessary. This creates a dual activity context where diagnostic inquiry is locally complete and the visit is moving through counseling toward closing, but in the broader trajectory of the patient's care, diagnostic inquiry is ongoing and neither a definitive nor a "good enough" diagnosis has been reached. This is indeed one context where patients tend to volunteer more information or push back against one or another of the potential diagnoses the physician has put forth. Because diagnostic inquiry remains omni-relevant, the patient's contributions are in some sense warranted, but in terms of the activity context of the visit, such actions present the same interactional challenges to physicians as those that occur after a more definitive diagnosis: although they are trying to move toward closing, the patient is pulling back toward information-gathering and making *some* kind of continued investigation or reassertion relevant. Consider Extract 9.

In this visit the patient has presented with a painful and swollen ankle following a basketball injury. The first thing the physician does in the physical examination is palpate the outer side of the ankle and ask if it hurts. When the patient confirms, the physician immediately says, "yeah you need an x-ray" (not shown). He then palpates other areas of the ankle, none of which cause much pain. Before moving on, as is common in pain contexts where a series of manipulations cause no pain, he returns to the painful spot to re-confirm (McArthur 2019) before reasserting "yeah you need an x-ray... definitely" (line 1). Reassertions in these contexts, where a physician has delivered some

diagnostic assessment early in the visit but has followed it with further *physician-initiated* information-gathering, display an orientation toward the relevance of reasserting an assessment after intervening information has been gathered. These provide a nice contrast with cases in which the *patient* has volunteered the intervening information, as it further underscores the missing-ness of a reassertion when the physician ignores it, brushes it off, or otherwise avoids the reassertion.

(9) AMH 02-12 Diagnostic assessment overlapping with end of physical exam

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          ((DOC bending over PAT's ankle, palpating))
1  DOC:   Yeah you need an #x-ray. Definitely.#
2          (0.5) ((DOC stands up and moves hand))
3  DOC:   .h[h
4  PAT:  ->  [<It's actually a little tender on the medial
5          -> side too ((points to spot on ankle)) which got
6          -> me a little w- ((DOC leans in to touch that spot))
7          -> concerned.=I'm like woah that's weird.=Yeah right
8          ther:e. ((nodding)) .hhh
9          (2.5) ((DOC bent over, palpating PAT's ankle))
10 DOC:   Hm:.
11          (0.5)
12 DOC:   Ye(h)ah.
13          (2.5) ((DOC continuing to palpate))
14 DOC:   .hhh Okay well- (0.2) °all the more reason
15          [( ) to take a look at it. °
          [((DOC looks up, establishes mutual gaze))
16 PAT:   [((laughs))

```

After this reasserted recommendation for an x-ray, the physician, who was bent over the patient's ankle palpating it, stands up and moves his hand further up the leg. This move could either be a move to a new physical exam activity, or a pre-closing move; the latter is more likely, as the physician never returns to this position after the intervening resistance sequence. In this transition space the patient comes in with an additional symptom description in lines 4-8 "it's actually a little tender on the medial side too which got me a little concerned... I'm like woah that's weird." (As a note, the physician does not yet know that the patient is a medical student training in physical medicine and rehabilitation, but immediately after this extract he comments on his use of "medial" and asks what he does for a living.) In response, the physician returns to palpate the inner side of the ankle. The patient confirms pain, unsolicited, with "yeah right there" in lines 7-8 (McArthur 2018),

adding an audible in-breath as the physician continues to palpate.

By commenting on his palpations with “hm” and “yeah” in lines 10 and 12, the physician confirms physical findings based on the patient’s comment. He then closes this sequence and activity, which was initiated by the patient’s symptom description, with “okay” in line 14 (Schegloff 2007). He then reasserts his x-ray recommendation with “okay well- all the more reason to... take a look at it” in lines 14-15. Here, rather than merely repeating his earlier recommendation as he did earlier following his own additional information-gathering (“yeah you need an x-ray”), the physician does work to incorporate the patient’s symptom description and soften hearable disagreement. By beginning with “all the more reason,” he casts the patient’s contribution as a further basis for the x-ray. However, he doesn’t repeat the word “x-ray” but rather says “take a look at it.” The closer to a full repeat a reasserted diagnostic assessment is, the more it may be hearably bracketing off the patient’s concerns and demanding a return to the physician’s own agenda. By instead reformulating the reassessment – and further, as here, doing so with *less* clinical language and with reduced amplitude relative to surrounding talk – the physician softens the disagreement that may be embodied by a straight reassertion. Nonetheless, this *is* a reassertion and a return to the physician’s agenda, albeit one that is produced within an aligning response frame that indeed takes up and incorporates the patient’s contribution. Indeed, in this case the patient orients to social trouble revealed by the physician’s reassertion with laughter in line 16 (Jefferson 1984a).

This section has illustrated three main ways physicians push back against diagnosis resistance without overtly disagreeing: returning briefly to history-taking and then moving on without comment; eliding the reassertion altogether through self-repair and restart; and incorporating the patient’s turn into the reassertion. As the strongest and most authoritative way a physician can push back against diagnosis resistance, reassertions are often accompanied by epistemic downgrades, accounts, and explanations, and thus come with an interactional cost in terms of both time and

authority. When those reassertions incorporate the patient's turn or obscure disagreement altogether, the need for such interactional work is sidestepped. These types of responses to diagnosis resistance are physician-centered because they observably work to move past the resistance and return to the physician's agenda as quickly as possible; this was further illustrated in the extracts above through other turn-design features that are characteristic of physician-centered responses, as outlined in Table 2.

In the next extract we'll see what physician-centered responses look like when pushback against the patient's resistance is *not* framed as agreeing or aligning and thus there is some persuading work to do, but the physician nonetheless tries to do so quickly and return to their own agenda. I call these types of response disagreement with "perfunctory persuasion."

Excursus: A brief comment on tests as a resource

Cases like the previous one, where a test has already been recommended prior to diagnosis resistance and is later reinvoked as a way to respond to the resistance, suggest that the test itself may be a resource for responding to resistance. Indeed, when a patient pushes for further diagnostic inquiry or assessment, it makes interactional sense to bring up a test in response, as a test by its very nature forestalls closure of the investigation of the patient's problem and introduces the possibility of further diagnostic inquiry or assessment in the future. One might thus expect physicians to *use* tests as a resource for shutting down resistance, even in cases where a test was not already recommended and may not be clinically called for. This is especially the case in primary care, where many tests like x-rays are oriented to as low-cost in terms of time and resources and can often be done on-site. Indeed, in many visits in the data, physicians recommend tests like x-rays that are *not* useful in diagnosing the problem and seem to be doing so "just in case," either out of personal cautiousness, or to address patient concerns; this behavior has been documented in other studies,

and contributes to the rising costs of healthcare in the US (Litkowski et al. 2016; Mafi et al. 2017; O’Sullivan et al. 2017; Whiting et al. 2017).

However, it does not appear that diagnosis resistance is contributing to this process, as physicians almost never offer new tests in response to resistance. In the AMH dataset new tests are recommended in response to resistance in a total of three cases. In two of these the recommendation is designed as a return to the physician’s agenda, and thus cast as something the physician was planning to do before the patient resisted; whether these tests were indeed prompted by the resistance and offered to assuage patient concerns is impossible to ascertain using conversation analysis. In the only case where the physician obviously changes course in response to the patient’s bid for a test, the patient is someone who has lived with HIV for a long time, and both participants treat him as having more expertise over matters like the need for lung x-rays than other patients. Thus, it does not appear, in this relatively small selection of visits among five physicians within a single healthcare organization, that diagnostic tests are being used as a resource for responding to diagnosis resistance.

b. Perfunctory Persuasion

Unlike the physician-centered responses shown so far, in this response category physicians push back against the patient’s resistance – through reassertions or, alternately, through responses I’m characterizing as “neutralizing” responses, which neutralize the threat presented to the physician’s diagnostic assessment but without explicitly reasserting it. When physicians disagree with patients, they do work to soften the disagreement and/or persuade them through accounts or explanations. This persuasion can be quite extensive, as I show in the next section on patient-centered responses. However, in the responses illustrated here, persuasive work is brief and what I’m calling “perfunctory,” and the response as a whole observably prioritizes returning to the

physician's clinical and interactional agenda rather than suspending progressivity to more expansively address patient concerns.

Perfunctory persuasion includes accounts and explanations that are relatively short – a single turn, turn construction unit, or even a single word or phrase – and do more to *assert* the physician's medical expertise than to actually make that expertise accessible to the patient. A distinction can be made, which was alluded to in Peräkylä's (1998, 2006) work on diagnosis, between mere references to the evidence, and explications of the evidence. The clearest example of this distinction is between an evidentialized diagnostic statement, e.g., "It looks like X," which merely incorporates a reference to the *existence* of evidence, and descriptions or explanations of what that evidence *is*. As Peräkylä argues, any reference to the evidence moves away from a purely authoritative diagnostic assertion toward a more subtle balance between authority and accountability to the patient for the evidential basis of the diagnosis. However, the extent to which physicians truly "account" for their diagnosis varies depending on the extent to which they explain the evidence: whereas more extensive attempts to explain do work to bridge the gap between the physician's and the patient's expertise, mere references to the evidence without (much) explanation persuade in a more perfunctory way.

On one hand the mere presence of evidentialization in response to diagnosis resistance orients to accountability, implicitly acknowledging the challenge to the physician's authority presented by the resistance. Indeed, any attempt to account for an assessment or persuade a patient represents a degradation of medical authority (Starr 1982). But references to the evidence that do little work to *actually* persuade the patient also function as an assertion of that authority; they more or less point out that the physician knows what the condition is, because the physician knows how to see and interpret clinical evidence – e.g., "I know you have X because I'm the doctor." Extract 10 illustrates a neutralizing response accompanied by perfunctory persuasion.

In this visit the patient presented with diarrhea and stomach discomfort, which the physician

has diagnosed as a viral infection. In lines 1-2 the physician, who has been sitting and facing the patient since the diagnosis, adds that he doesn't "think we have any reason to suspect anything else." In response the patient presents a bacterial infection as a candidate understanding of this rule-out with "you don't think it's like bacterial or anything like that" in lines 3-4. This resistant question places greater constraint on the physician to respond compared to resistant statements, and more directly challenges the diagnosis. Nonetheless, like most resistance in the form of a question, it also orients to the physician's authority over such matters, giving the physician an "easy out" through its yes/no design and its grammatical preference for a response that indeed would neutralize the resistance.

(10) AMH 02-11 Counseling

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          ((DOC sitting, facing PAT))
1  DOC:   I don't think we have any reason to suspect
2          anything else.
3  PAT:  ->          [>You don't think it's like bacterial
4          -> or any[thing like that.<
5  DOC:          [Nah.
6  PAT:   [Okay.
7  DOC:   [No: way.
8          (0.2)
9  PAT:   Okay.
10 DOC:   No.<It's not [acting bacterial.=It's [acting like
11 PAT:          [Okay.          [Mm:.
12 DOC:   viral.<.h[h So it's- you're already doing what you
13 PAT:          [Okay.
14 DOC:   should be doing.

```

The physician minimally neutralizes the threat presented by the candidate diagnosis with "nah" in line 5 in overlap with "or anything like that" and "no way" in line 7, at the transition relevance place. The patient accepts this neutralizing response with two "okays" in lines 6 and 9. Nonetheless, in lines 10-11 the physician adds another "no" followed by a reference to the evidence for his diagnosis "it's not acting bacterial. it's acting like viral."

On its face this reference to the evidence displays some accountability to the patient for the evidential basis of the diagnosis. In terms of content, though, it explains nothing to the patient,

making nothing about the evidence itself available to her. To say that her condition is “acting” viral rather than bacterial embeds expertise about how to recognize viruses “acting” in one way or another. Whatever work this is doing to persuade the patient is more along the lines of “I know it’s viral because I have the medical expertise to recognize when something is acting viral” rather than any kind of explanation bridging the gap between the participants’ expertise and getting “on the same page” about why this is recognizably not a bacterial infection. In other words, it is more of an expression of authority than an accounting for the diagnosis *per se*. That is what makes this persuasion perfunctory, and it can be contrasted with the kinds of persuasion I show in the next section on patient-centered responses, where physicians work to bridge the gap through explanations that, for example, tie to the patient’s understanding or experience of their health problem. At the turn transition space at the end of this perfunctory persuasion, the physician does an in-breath that is fast and loud, giving it the feeling of an “abrupt-join” (Local & Walker 2004), and maintains the floor to move straight into treatment talk, obscuring the space for patient response and pivoting back to his own clinical agenda.

c. Minimal Answers to Resistant Questions

This final section on physician-centered responses illustrates a distinct kind of response that is shaped by the sequential environment in which it occurs: resistant questions. As previously mentioned, questions place greater constraint on physicians to respond compared to resistant statements, and more directly challenge the diagnostic assessment. But they also generally display an orientation to the physician’s authority over the matter asked about and give the physician a relatively “easy out” by minimally answering the question and moving on.

In the following a physician neutralizes resistance through a minimal answer to a question about symptoms. Like most questions that present a challenge to a diagnostic assessment, this is a

yes/ no question that grammatically prefers the answer that indeed neutralizes the resistance and thus agrees with the original assessment (Heritage & Raymond 2021). This question design gives physicians an even “easier out” in that a minimal yes or no (or variant thereof) would satisfy the constraints of the question, meeting the topic and action agenda *and* technically agreeing with the patient (Heritage 2010; Heritage & Clayman 2010) – without addressing whatever underlying concerns may have motivated the question. Consider Extract 11.

In this visit the patient presented with swelling around his elbow that began some weeks ago when he heard and felt a “snap” and experienced pain when straightening his arm. The physician diagnosed the swelling as olecranon bursitis, which is swelling of a fluid-filled sac in the elbow, and a skin infection. This diagnosis addresses the pain and swelling in the elbow, but not the snap. As we learn much later in the visit, the patient has an underlying condition that makes him prone to muscle tears, and his concern was more about the snap than about the swelling *per se*. The patient pushed for comment on the snap just after the diagnosis, but the physician brushed it off. The physician then used a needle to draw fluid from the patient’s elbow, which helps reduce the pressure and swelling. During this procedure the patient asks in lines 1-2 “you think the fluid and all this trauma came from somewhere else?” which resists the fact that the physician has not addressed the snap.

(11) AMH 02-03 Counseling

 ((DOC sitting, treating PAT’s elbow, NUR present))
1 PAT: You think the fl-fluid and all this the trauma came
2 from somewheres else?
3 DOC: Um. ((standing up))
4 PAT: Bec[ause-
5 DOC: [Sorry ((nurse name)), ((walking toward glove box))
6 NUR: [That's okay,
7 PAT: [You know what I mean?
8 DOC: Um. I don't think so. I think it was probably from when
9 you heard that noise. ((retrieving pair of gloves))
10 (1.2)
11 PAT: [Oka:y,
12 DOC: [Probably (when)-
13 (0.8)
14 DOC: U[m. ((turning to walk back))
15 PAT: -> [A- And I would lose strength like tha:t?
16 DOC: .pt .h Yea:h. ((putting on gloves, facing away from PAT))

17 PAT: Okay,
18 (1.0) ((still putting on gloves, turns to face PAT))
19 DOC: .hh Well I think=hh I think you may have avulsed (0.5)
20 um (0.2) a part of the tendon y'know from the bo:ne,

As the physician stands and walks across the room to retrieve a pair of rubber gloves from a box on the wall, he responds with “I don’t think so. I think it was probably from when you heard that noise” in lines 8-9. Here again he declines to clinically expand on the snap, even avoiding the word “snap” itself and referring to it instead as “that noise.” After a 1.2-second silence, the patient responds with a rising-intoned “okay” in line 11, treating the physician’s response as insufficient and pursuing elaboration. He then adds the focal instance of resistance in line 15, asking “and I would lose strength like that?” As discussed in Chapter 2, when compared with symptom descriptions, questions about symptoms more explicitly question the fit between the patient’s symptoms and the diagnosis, and thus more directly challenge that diagnosis. Action-wise, they constrain the physician to minimally confirm the fit. Here the physician does just that and nothing more with an elongated “yeah” in line 16, still facing away from the patient.

The physician’s “yeah” answers the question, and – as in all cases of minimal neutralizations – supports the original diagnosis. But he does nothing more, answering the question at face value and declining to acknowledge or engage with the resistance embodied in the question. The patient responds with another rising-intoned “okay” in line 17, treating this response as insufficient, after which the physician turns to fully face the patient and diagnostically expands on the snap in lines 19-20 (the beginnings of an instance of a more patient-centered response). By doing so, the physician aligns with the patient’s orientation to the “yeah” as insufficient, and to his question as seeking more than confirmation, but rather expansion about the diagnosis.

d. Summary

Table 3 shows the distribution of the subtypes of physician-centered responses. Nearly half

of physician-centered responses are made up of some form of obscured disagreement (doing more history-taking and then moving on, incorporating a patient’s turn into a reassertion, and elided reassertions); just over a quarter are reassertions/ neutralizations with perfunctory persuasion, and one-fifth are minimal answers to questions. What these response types have in common – underscored by other features distilled in Table 2 – is that they observably work to move past the resistance and return to the physician’s agenda as quickly as possible. In the next section I show how patient-centered responses, in contrast, work more expansively to acknowledge or address patient concerns before moving on.

Table 3
Distribution of physician-centered responses

Response type	<i>Frequency</i>	<i>Percent</i>
Obscure disagreement	27	47%
Perfunctory persuasion	15	26%
Minimal answer to question	12	21%
Other	3	5%
Total	57	99%

Note: percentage totals subject to rounding effects

3.4.1.4 Patient-Centered Responses

Unlike physician-centered responses to diagnosis resistance, patient-centered responses work to more expansively acknowledge or address patient concerns before moving on and are characterized by a set of common features that reinforce the sense that the physician is making an effort to suspend progressivity of the visit to focus on the patient’s agenda before returning to their own (see Table 2). In this section I show two kinds of patient-centered responses – those which align with the patient’s resistant turn, and those which disalign.

a. Aligning Responses

The concept of alignment in interaction deals specifically with the ongoing *activity* – aligning actions are those which support some ongoing activity another speaker is displaying being engaged in, and disaligning actions undermine it (Stivers 2008). In the context of diagnosis resistance, patients invite a return to a prior activity, specifically information-gathering/ diagnostic inquiry. Physicians may align with this move by indeed returning to that activity, or disalign by working to remain in the current counseling activity context.

In the first extract I show a reassessment, and in the next extract I show a return to information-gathering followed by a reassertion, both of which I argue are aligning responses.

Reassessments include new diagnoses, elaborations of an original diagnosis or its etiology that include new diagnostic information or terminology, and discussions of the possibility of some candidate diagnosis suggested by the patient. Consider Extract 12.

In this visit the patient says she thinks she has the flu, “but a very weird flu” (not shown). She describes fatigue and body aches followed by a short bout of congestion, which has now been followed by severe heartburn and indigestion, as well as stomach pain and diarrhea. After physical examination, the physician diagnoses her by saying “I don’t know if this is the same virus that you had or a new one... but definitely it sounds like a virus” (not shown); he then recommends Pepto Bismol. The patient engages in some diagnosis resistance throughout the treatment recommendation, adding new information that she’s had a long history of stomach issues and emphasizing the severity of her heartburn (not shown).

In lines 1-2 the physician is agreeing with the patient’s suggestion that she take Zantac, a heartburn medication. She accepts this with “okay” in line 3, and the physician bids for closure with another “okay” in line 4. In this impending transition space, the patient asks, “so this might be a new virus,” in line 5, grimacing. This revisits the physician’s own mention of the possibility that this could be a new virus and might on its surface merely be requesting elaboration of the question of

whether it's the same or a new virus. However, the stress is on “virus” rather than “new” which contrasts with other, non-virus causes of the patient’s stomach pain and thus resists the entire diagnosis, however minimally. The physician responds with an affirmative, albeit downgraded, answer (“I think it might be” in line 7), which is then expanded in a more patient-centered way in lines 7-37.

(12) AMH 02-09 Counseling

((DOC leaning against counter, facing PAT))
 1 DOC: But I think you're right you should (.) take
 2 the Za:ntac t[oo. ((standing and moving from PAT))
 3 PAT: [Okay.
 4 DOC: O[kay,
 5 PAT: -> [So this might be a new virus, ((grimace))
 6 (0.2)
 7 DOC: **I think it might be [because you were saying (.)**
 8 **[(DOC returns to leaning)**
 9 DOC: **'cause what you had before .h[h [it-**
 10 PAT: [It wa[s- ((shaking
 11 head)) Ye[ah.
 12 DOC: **[I don't think it was the flu but it**
 13 **sounds like a classic cold virus.**
 14 PAT: [°O::h°
 15 DOC: **[.pt .h And the:n your son: (.) um had that**
 16 **little episo:de?**
 17 PAT: [Yea:h.
 18 DOC: **[And it may: be that he was nursing something,**
 19 **and you picked it [up a couple days before he**
 20 PAT: [°°(Yeah)°° ((smiling))
 21 DOC: **even got sick, ((smiling))**
 22 PAT: O[:kay. ((smiling, nodding))
 23 DOC: **[.h and then you got sick. ((smiling, nodding))**

The expansion begins with “because” in line 7, at which point the physician, who was beginning to move away from the patient, returns to his prior post leaning against a counter just next to the patient and gazing at her. He immediately ties the coming explanation to the patient’s own reports with “you were saying” in line 7. He then backs up and expands on what he means by “new virus.” He starts with the first virus, saying in lines 12-13 that what she “had before,” meaning the original fever and congestion, “sounds like a classic cold virus” rather than a flu as the patient had originally supposed. He then moves forward in the timeline, transforming this into a narrative explanation, with “and then your son had that little episode?” in lines 15-16. This ties back to an

earlier history-taking sequence where he asked if her son was sick, and she reported that he was throwing up and feverish. He then explicitly unpacks how this may have led to a “new virus” in lines 18-23, with “it may be that he was nursing something, and you picked it up a couple days before he even got sick, and then you got sick.” This provides an explanation for how the patient could have gotten a second virus, as well as an account for the patient’s experience of the timeline, in which the two viruses happened so closely together that they seemed like one “weird flu.” The patient begins smiling with a “yeah” in line 20, affiliating with this explanation, and the physician picks up and reciprocates the smiles in line 21. The patient then adds an “okay,” smiling and nodding, and lengthening the “o” in a way that conveys both acceptance and a change of state (i.e., “Oh okay”) (Heritage 1984b; Schegloff 2007).

In lines 25-26 the physician brings his explanation to a close by re-stating, with a turn-initial inference-marker “so,” that she “may have gotten two viruses back-to-back.” The patient takes this up with laughter in line 27, adding “that’s what I was thinking.” This overtly accepts the physician’s assessment in a way that claims some diagnostic reasoning of her own (Peräkylä 2002, 2006) and displays alignment between that reasoning and this explanation. Notably, though, everything up until now – i.e., her original description of her problem as a single “weird flu,” her later diagnosis resistance pushing for consideration of a more serious stomach issue, her question initiating this explanation, and her change-of-state behavior during it – has conveyed that this is *not* what she originally thought. The physician indeed displays an understanding of her prior reasoning as different from his current explanation when he adds an acknowledgment that it *could* have been a single illness: “sometimes the viruses start up high and then go into the intestine, not as often?” in lines 29-31. This addition provides for the possibility of a single “weird flu,” and legitimizes her suspicion of her illness as such. It also, however, demonstrates clinical expertise and may be pushing back against the patient’s claim to diagnostic reasoning.

22 PAT: O[:kay. ((smiling, nodding))
 23 DOC: [.h and then you got sick. ((smiling, nodding))
 24 PAT: [Yeah.
 25 DOC: [y'know,<.h so you ma:y have gotten two viruses
 26 back to [back.
 27 PAT: [thh heh heh That's what I [was thinking.
 28 DOC: [But- ther-
 29 there ar- sometimes the viruses start up high
 30 and then go into the intestine,=not- not as
 31 often? ((shrugs)) .hh
 32 PAT: Mm [hm,
 33 DOC: [So- but with a little kid around y'know
 34 ((shrugs))
 35 PAT: O:kay.=
 36 [(DOC shifts gaze away, moves away from PAT))
 37 DOC: [=You're- you can get [everything right,=
 38 PAT: [I- Okay.
 39 DOC: =eh [heh heh heh heh .hh ((walking to door))
 40 PAT: [Yeah=h heh heh heh yea:h. ((shrugs))
 41 DOC: Okay.
 42 PAT: O[ka:y.
 43 DOC: [.h Hey thank you for=uh working with Amanda...

The physician then returns to his prior reference to the patient's son with "but with a little kid around y'know ((shrugs))" in line 33. Coming on the heels of the just-prior acknowledgment of an alternate explanation, this addition casts the son's illness not only as *explanatory*, i.e., helping the patient understand her illness, but also as part of an *account*, i.e., making a case for the physician's diagnostic reasoning for why it's more likely that the patient had two viruses than one. The patient accepts this with "okay" in line 35, and the doctor, who had been leaning against the counter this whole time, begins to move away from the patient, adding "you can get everything, right," in line 37. This marks a closure and an impending shift to some next activity both in an embodied way, and because the turn shifts from clinical explanation to a sort of truism and commiseration that is more characteristic of everyday talk. The patient takes up this bid for closure with "okay" in line 38, and in lines 39-40 they laugh together. The whole sequence comes to a close with back-to-back "okays" (Schegloff & Sacks 1973) in lines 41-42 before the physician moves toward closing by thanking the patient for participating in the research study.

The physician's response to the patient's resistant question is patient-centered in a number

of ways. First, his embodied behavior shows a commitment to halting progressivity toward closing in order to address the patient's concerns, as he interrupts his own prior movement away from her and returns to his post leaning against the counter and facing her. The explanation he appends to his answer is an expanded, multi-turn project which provides plentiful opportunities for patient uptake and acceptance. Moreover, the explanation itself accounts for the physician's diagnostic reasoning, ties to the patient's subjective experience of her illness and to her own reports and addresses her earlier displayed understanding of her illness. When the physician moves toward closure, it is in a context of extended patient acceptance, alignment and affiliation, as well as repeated, collaborative bids for topic closure. Taken together, these features mark a distinct contrast with the more physician-centered responses illustrated above.

Another way physicians respond in a way that aligns with the patient's resistance is by returning to information-gathering followed by a reassessment or reassertion of the original assessment. This includes additional history-taking or physical examination within the activity context of the current health problem, although in some cases physicians treat a volunteered symptom or other information as cause to initiate a *new* investigation of a different health problem. Returning to information-gathering may lead to a new or different assessment, but I also consider aligning responses to include reassertions of the original assessment that are designed so that the patient can see that it's inferentially based upon the new information received. These returns to information-gathering can be contrasted with the physician-centered version illustrated in Extract 7, where the physician obscures the slot where a reassessment or reassertion should normatively occur given new information. Consider Extract 13.

In this visit the patient has presented with bad congestion for a week, a sore throat, body aches and fever. He emphasizes that it's getting worse instead of better and adds that he "never gets sick" and "if I do it's not for a week" (not shown). Notably, he does *not* suggest a sinus infection,

neither explicitly nor via classic symptom descriptions like “green mucus” (Stivers 2002a, 2007; Filipetto et al. 2008). The physician recommends an on-site rapid strep test, but then adds a diagnosis, saying that “it looks to me and sounds to me from what you’re describing like a classic viral syndrome” (not shown). After some more explanation and accounting, the physician recommends over the counter “supportive care” and “symptomatic relief.” The patient accepts these treatment recommendations but adds “is there anything that I could pick up at the pharmacy for the sinuses” in lines 3-4 below. This is a new symptom description framed as a treatment question, as the patient has not previously mentioned his sinuses, nor has the physician asked about them. The physician orients to the missing-ness of discussion about the patient’s sinuses with “yeah I wanted to actually ask you about that” in lines 5-6. By initiating his return to information-gathering this way, the physician casts it as something he was going to do *before* the patient pointed it out and thus independently of the patient’s resistance; but this at the same time legitimizes the patient’s push – however covert – for him to consider the sinuses.

The physician then asks a series of questions in lines 6-7, 16-17, 22-23, 28, and 32-34 which target signs of a sinus infection – sinus pain, colorful “drainage” from the nose, prior sinus issues, and fever. The patient confirms pain in lines 8-13, which the physician treats as potential cause for concern and reassessment with “really. Okay. That does concern me a little bit” in lines 14 and 16. The rest of his questions, however, are indicative of no problem. Nonetheless, for each of his subsequent answers, the patient responds in ways that observably prioritize confirmation of an infection, and thus push for reassessment of his problem.

(13) AMH 02-02 Counseling

```

          ((Rx talk about NyQuil))
1  PAT:   Oka:y,
2  DOC:   .h[h
3  PAT: -> [And is there anything I could pick up at a
4         -> phararmacy, for:um (0.2) for the sinus[es, ( )
5  DOC:                                     [Yeah I
6         wanted to actually ask you about tha:t=are- are

```


32 DOC: heh (d)Yeah. .hh Um: A::nd (0.5) you don't have a
 33 fever no:w do you (g-) do you feel like you had a
 34 fever:: earlier today or yesterday,
 35 PAT: Maybe late yesterday.
 36 DOC: Okay,
 37 PAT: Not today,
 38 DOC: So what you seem to ha:ve is- just like I thought
 39 you have a viral syndrome and you've got some sinus
 40 (0.8) some sinus pressure because thee: um (.) .h
 41 the sinuses are aerated through the no:se and the
 42 nose is all stuffy,
 43 PAT: [°Okay°
 44 DOC: [.h So- u:m have you used a Neti Pot befor:e,

Nonetheless this *is* a reassertion, which as I have suggested comes with additional work; the physician here adds an explanation of why the patient may be feeling sinus pressure despite no sinus infection in lines 39-42 (the “sinuses are aerated through the nose and the nose is all stuffy”). He then moves on to treatment recommendation for a Neti Pot – a device for irrigating the nasal canals and relieving sinus pressure. Although transitioning to treatment moves on from the resistance sequence, the recommendation builds on the information revealed in that sequence, somewhat legitimizing the patient’s resistance.

On one hand the explanation that accompanies this reassertion is somewhat brief, not all that informative, and observably geared toward a move toward treatment; in these ways it’s reminiscent of a physician-centered reassertion. What makes this a patient-centered response is the fact that the physician returned to somewhat extensive history-taking, and then framed his reassertion as *the result of* reassessment based on that history-taking. In other words, the physician treated the patient’s concern about his sinuses, which so far had been unaddressed, as legitimate; he took those concerns under diagnostic consideration; he showed a willingness to reconsider the diagnosis in light of the patient’s concerns; and he ultimately framed his reassertion as further informed by, and confirmed by, investigation of those concerns.

b. Disaligning Responses

In the case of disaligning patient-centered responses, physicians push back against the patient's invitation to return to information-gathering/ diagnostic inquiry through reassertions of the original diagnostic assessment or neutralizing responses to resistant questions. In the case of patient-centered responses, however, they combine their pushback with work to connect to the patient's own perspective or theory of the illness. For example, rather than merely referring to the existence of the evidence, as in Extract 10, physicians may fully explain both negative and positive evidence in support of the diagnosis. Physicians also sometimes tie their explanations of the diagnosis to the patient's own reported symptoms; explain diagnostic uncertainty; add diagnosis-relevant contingency plans; elaborate on the etiology of the patient's problem; explicitly validate the patient's concerns about the diagnosis; and so on. Consider Extract 14.

In this visit the patient has presented with leg and back pain, which the physician has diagnosed as sciatica. Earlier in the visit the patient indeed mentioned sciatica as a candidate diagnosis. In response, the physician said "it sounds like sciatica" (not shown). However, the patient then cast doubt on this diagnosis by explaining that he tried some exercises recommended for sciatica, which just made the pain worse. During the physical exam, the physician commented that the patient's painful leg is "a little weaker," which he says "is not unexpected with sciatica." There is no actual diagnostic utterance in this visit, as the patient initiates movement straight to treatment by asking about a cortisone shot, which he says helped some co-workers. They talk about this, and then the physician moves on to a series of other recommendations (anti-inflammatories, avoiding certain activities, physical therapy) that are consistent with a sciatica diagnosis.

In the opening lines of the extract the physician is finishing up his recommendation for physical therapy by saying he'll place a referral in line 1. The patient accepts this with "okay" in line 3, and the physician begins to move toward this new activity by turning toward the computer and then doing a lip smack as he points and scoots toward it. But before he can initiate this new activity

the patient begins a candidate diagnosis suggestion in the form of new information in line 6, saying that both his mother and grandmother had rheumatoid arthritis. During this, the physician begins typing and scrolling on the computer. In line 8 he takes up the patient's comment but treats it as unfinished with a rising-intoned "okay," but suspends his typing. The patient pursues response by re-completing his turn in line 10, unpacking his comment by explicitly tying this candidate diagnosis to himself with "so I guess I'm in the gene pool for that." Again, the physician treats him as unfinished with a rising-intoned "mm hm" in line 11. The patient then makes another move to pursue comment on this candidate diagnosis with "would that have?" in line 12. This question elides the actual suggestion that *this* problem could be rheumatoid arthritis, and after more than a second of no response from the physician, he finally makes the connection explicit with "is that a possibility here," in line 15. This series of turns is a good example of how patients may prioritize more implicit forms of diagnosis resistance like descriptions of symptoms and avoid, if possible in the local interactional context, explicitly questioning the physician's expertise (see Chapter 2).

(14) AMH 01-15 Counseling

```

          ((DOC facing PAT, closing talk re: physical therapy))
1  DOC:   So I'm gonna place a referral for that too.
2          (0.5)
3  PAT:   Okay.
4          (0.5) ((DOC turning gaze to computer))
5  DOC:   .pt ((points to computer and scoots chair toward it))
6  PAT: -> So: my mother:, [(0.2) and my: grandmother::
          [(DOC begins clicking mouse, typing))
7          -> were both rheumatoid arthritis?
8  DOC:   Okay, ((gazing at computer, but suspends clicking/typing))
9          (0.8)
10 PAT: -> S:o::=[I guess I'm in the gene pool for tha:t,
          [(DOC gaze moves toward PAT))
11 DOC:   Mm hm:,
12 PAT: -> Would that have?
13          (1.2)
14 DOC:   [.hh
15 PAT: -> [Is that a possibility here,
```

The physician responds by disconfirming the candidate diagnosis and ultimately reasserting the diagnosis of sciatica in lines 16 through 38. As an answer to the patient's question, especially in a

context where the patient himself suspected sciatica and is likely *hoping* for a rule-out of rheumatoid arthritis, this is an aligning response. But at the same time, suggesting an alternate diagnosis and thus presenting a challenge to the diagnosis invites a return to information-gathering and/or re-assessment; in this context, a neutralizing response followed by a reassertion is also in a way disaligning. But as opposed to the neutralizations and reassertions seen in the last section, which were somewhat minimal and produced in the course of an observable attempt to shut down the resistance and move on, this one is more patient-centered.

The physician begins with “that’s a good question” in line 16, which validates the patient’s concern and indicates a more expanded multi-unit response to come. And although he is still oriented toward the computer he has not returned to typing, and gazes at the patient around the boundaries of his turn construction units. Thus, although his continued orientation toward the computer declines to abandon this pending next activity completely, he is using the computer not so much as a competing activity, but more as a “home position” (Schegloff 1998; Sacks & Schegloff 2002) for his gaze when he’s not looking at the patient; indeed, looking away like this is not unusual, as mutual gaze is rarely continuously sustained during extended turns at talk (Goodwin 1980; Rossano 2012).

The physician rules out the candidate diagnosis of rheumatoid arthritis in a downgraded way by adding that, in the patient’s case “it’s pretty unlikely” in line 17. He then adds “based on my exam” in line 19 which, as an evidentialization without explanation, would be rather physician-centered; however he will go on to extensively unpack what he means by this.

```
14 DOC:      [.hh
15 PAT: -> [Is that a possibility here,
16 DOC:      That's a good question: . u:m So in your? ca:se?
17          (0.2) u:m it's it's pretty unlikely.
18          (.) ((DOC oriented to comp but not typing;
                gazing periodically at PAT))
19 DOC:      based o:n=u:h my exam.
20          (0.2)
21 PAT:      [Okay,
```


33 PAT: [Okay.
34 DOC: .h u::m <but- (0.2) if you- (0.2) develop any
35 of those [symptoms certainly we can consider.
[((gazes at PAT, moves hands to keyboard))
36 PAT: Ka[y.
37 DOC: [.h um and yours is a [pretty classic case
[((one hand to mouse, gaze
[at computer, begins to click/type))
38 DOC: [for:=u:h (0.5) uh sciatica.
39 (.)
40 DOC: fortunately,
41 (.)
42 DOC: is very treatable.
43 (0.2)
44 DOC: It's very very treatable. ((continuing to type))
45 PAT: Okay so you think the pain will go away,=
46 DOC: =oh yeah.

Toward the end of this turn, the physician simultaneously turns his gaze toward the patient and returns his hands to the keyboard. His gaze pursues patient uptake, but by doing so also marks the end of the turn (Stivers & Rossano 2010; Rossano 2012); coupled with a return to the keyboard, the physician's behavior displays an orientation to the contingency plan as closure-relevant, and to his entire response package as sufficient. The patient accepts with "kay" in line 36, and the physician, beginning to type, reasserts the original diagnosis with "yours is a pretty classic case for sciatica" in lines 37-38. The physician's embodied behavior here treats the reassertion as embedded within a return to his prior agenda, which is nice evidence in support of reassertions, by themselves, being oriented to the physician's agenda. He then adds "fortunately is very treatable, it's very very treatable" in lines 40-44. This simultaneously turns to the bright side of the matter (Stivers & Timmermans 2017) and moves on to treatment, both of which bid even more strongly for closure of the prior sequence and resumption of progressivity toward visit closing. The patient aligns with this attempt to move on with "okay so you think the pain will go away," in line 45, which the physician confirms.

In this multi-turn response to the patient's candidate diagnosis, the physician has neutralized the threat posed to his assessment and then reasserted that assessment. But along the way, he has

validated the patient’s concerns, explained the negative evidence in support of his diagnosis in a way that ties to the patient’s illness experience, and provided a contingency plan that creates a future opportunity space, however unlikely, for reassessment. This work shows much more accountability for helping the patient understand the diagnosis from his own perspective, which is both less authoritative and more patient centered. It also takes much more interactional time, and in this way – along with the physician’s embodied behavior which at least partially abandoned his move to the next activity – prioritizes addressing the patient’s concerns rather than immediately shutting down the resistance and getting back to the physician’s agenda.

c. Summary

Table 4 shows the distribution of the subtypes of physician-centered responses.

Table 4
Distribution of patient-centered responses

Response type	<i>Frequency</i>	<i>Percent</i>
Aligning	28	72%
New or elaborated assessment	15	
More Information-Gathering + Reassessment	10	
Other	3	
Disaligning	11	28%
Total	39	100%

Nearly three quarters of all patient-centered responses are aligning responses, with the majority of those made up of new or elaborated assessments. These are typically not full retractions or revisions of original diagnoses but are more often new or elaborated diagnoses in a context where the physician did not originally diagnose the problem or did not fully diagnose it. Conversely, just over a quarter of patient-centered responses are disaligning. What these response types have in common – underscored by other features distilled in Table 2 – is that they observably work to more

expansively acknowledge or address patient concerns before moving on when compared to physician-centered responses.

As I mentioned earlier, disagreeing or disaligning responses like neutralizations or reassertions are often accompanied by epistemic downgrades, accounts, and explanations – that is, when they are not framed in an agreeing response. Sometimes these accounts and explanations are more minimal, perfunctory, and assertive of authority rather than persuasive. But the more patient-centered ways of doing this, as seen in the prior extract, seem to come with a high interactional cost in terms of time and authority. In the remainder of this chapter, I examine the distributions of response types across specific clinico-interactional contexts, which suggest that physicians may generally avoid this cost by (1) responding to diagnosis resistance with brush-offs and physician-centered responses far more often than patient-centered responses, and (2) reserving the more extensive patient-centered responses for specific contexts, including more overt types of resistance and persistent resistance.

3.4.2 Distributions of Response Types

3.4.2.1 Overall Distribution

Looking at the overall distribution of physician response categories, as illustrated in Table 5, suggests a general physician tendency toward responses that brush off patient resistance or shut it down quickly (physician-centered responses), and away from the lengthier, somewhat more accommodating patient-centered responses.

Table 5
Distribution of response categories

Response category	<i>Frequency</i>	<i>Percent</i>
Brush off	101	51%
Physician-centered	57	29%

n=197 → 177 response slots following discrete instances of resistance (6 cases omitted because patients obscured the response slot and moved on) + 20 slots following bare pursuits (see Data section)

This table offers a glimpse at what, across the data, physicians “do” with the interactional slots following any patient push for a return to information-gathering or diagnostic inquiry. What is most remarkable is the sheer frequency of brush-off responses, which account for just over half of all responses in the dataset. In the next section I examine the immediate contexts in which these categories of response occur, i.e., which types of resistance types they tend to follow.

3.4.2.2 Distribution of Response Types Across Types of Resistance

Table 6 breaks down the distribution of physician response types according to which of the three broad types of diagnosis resistance they tend to follow. As discussed in Chapter 2, resistant actions in the clinical domain include inquiring about a diagnostic test, questioning exam or test findings, inquiring about a candidate diagnosis, and requesting a diagnostic assessment. These actions present a stronger incursion into the physician’s domain of expertise, and as questions are more interactionally constraining. Conversely, resistant actions in the lifeworld domain include describing symptoms or other aspects of the patient’s illness experience, which do not present an incursion into the physician’s domain of expertise, and as A-event statements are less agentive and constraining. Resistant actions which cross domains include framing something substantively in one domain, e.g., a symptom description, in the format of the other domain, e.g., a question; these actions blur the boundaries between actions in the clinical and lifeworld domains and sit somewhere in between them in terms of the overtness with which they challenge a physician’s expertise.

Table 6

Distribution of response categories by resistance domain type – *N (%)*

Brush off	Physician-centered	Patient-centered	Totals
-----------	--------------------	------------------	--------

Clinical domain	4 (13%)	14 (47%)	12 (40%)	30 (100%)
Cross domain	10 (30%)	14 (42%)	9 (27%)	33 (99%)
Lifeworld domain	75 (66%)	25 (22%)	14 (12%)	114 (100%)

p < .001

Note: percentage totals subject to rounding effects

n=177 → total response slots following discrete instances of resistance (6 cases omitted because patients obscured the response slot and moved on); this table does not include 20 slots following bare pursuits

This table shows two trends in the data. First, the more overt an instance of resistance is, the more likely physicians are to respond in a patient-centered way (40% of responses to resistance in the clinical domain, 27% of responses to resistance that crosses domains vis-à-vis content and format, and only 12% of responses to resistance in the lifeworld domain). Conversely, the less overt an instance of resistance is, the more likely physicians are to brush off the resistance in the patient’s turn (13% of responses to resistance in the clinical domain, 30% of responses to resistance that crosses domains vis-à-vis content and format, and a full 66% of responses to resistance in the lifeworld domain). The patterns in this table are strongly statistically significant (p<.001).

These findings suggest two interactional forces shaping how physicians respond to diagnosis resistance: the directness of the challenge to the physician’s authority, and the ease with which an action *can* be brushed off. Actions in the patient’s lifeworld domain do not challenge the physician’s clinical expertise directly and tend to be more off-record *as* resistance than actions in the clinical domain. Indeed, as we saw in the extracts above, when physicians brush off patient resistance, it’s often in a context where actions that don’t look like resistance in the first place are not being treated as resistance. Actions in the lifeworld domain also tend to be formatted as assertions rather than questions. Taken together, these features may make resistant actions in the lifeworld domain easier and more likely to be brushed off than those which cross domains, and far easier than those in the clinical domain. This is particularly noteworthy in a context where most patient resistance *is* less direct and off-record. In other words, brush-off responses are so prevalent in part because patient

resistance is implemented most often via actions in their own domain, and physicians brush these off the most.

As I have suggested earlier and will address in more depth in the discussion section, brushing off patient resistance affords physicians the fastest return to their own interactional agenda. This is because turns that do not overtly look like resistance and are not observably heard as resistance present no accountable threat to the diagnostic assessment and make no accountable bid to move backwards in the visit. Conversely, attending to the resistance embodied in a patient's turn comes with costs in terms of both medical authority and the interactional time it takes to address patient concerns and move on. In this section I have shown that physicians may indeed reserve the lengthier, somewhat more accommodating patient-centered responses for more overt forms of resistance, which indeed occur less frequently. In the next section I examine the broader interactional contexts of physician responses, showing that physicians may also reserve more patient-centered responses for contexts of persistent resistance.

3.4.2.3 Timing of Patient-Centered Responses

Table 7 shows the overall timing of patient-centered responses relative to patient resistance. Whereas in previous tables the unit of analysis was individual physician responses to diagnosis resistance, in this table it is the visit itself. The *n* (70) includes all counseling phases for diagnosable problems with at least one instance of resistance. Cases were coded according to the timing of patient-centered responses in three potential positions: immediate, i.e., in response to the first instance of resistance in the visit; late, i.e., in response to some subsequent instance of resistance; and no patient-centered response. Coding was conducted a la survival analysis: if an immediate patient-centered response occurred, the case was coded “immediate” and not coded for later patient-centered responses (but see comments below regarding the relative lack of repeat patient-centered

responses). Of the remaining cases, those containing a later patient-centered response were coded “late,” and the remainder were coded “no patient-centered response.”

As Table 7 shows, in 20% of visits containing diagnosis resistance a patient-centered response was delivered late. Within this category of visits the average number of instances of resistance preceding a patient-centered response is 4.6 (s.d. 2.6), with the longest series consisting of 11 instances of resistance preceding a patient-centered response. This category thus represents those cases where physicians wait to respond in a patient-centered way, responding first in ways that brush off or otherwise ignore the patient’s resistance or more generally take a physician-centered approach.

Table 7
Timing of patient-centered responses

Response timing	<i>Frequency</i>	<i>Percent</i>
Immediate patient-centered response (i.e. pat-cent resp to first instance of resistance)	17	24%
Late patient-centered response (average # instances of resistance until pat-cent resp=4.6; s.d.=2.6; max=11)	14	20%
No patient-centered response (average length: 2.0 instances of resistance; s.d.=1.5; max=8)	39	56%

n=70 diagnosable problems containing at least one instance of resistance during counseling, out of 122 total diagnosable problems across 80 visits

In a further 56% of visits containing diagnosis resistance there is no patient-centered response whatsoever. This category includes cases where patients persist beyond a first instance of resistance and later abandon their resistance before a patient-centered response is produced, as well as cases where patients abandon their resistant project after the first instance. The average length of patients’ resistant projects in this category is two instances of resistance (s.d. 1.5), with the longest series consisting of 8 instances of resistance. These series of resistance are on average somewhat shorter than those preceding a late patient-centered response. In these cases, the patient may thus have abandoned their resistance *before* the physician would have produced a patient-centered response. These data also suggest, though more tenuously, that physicians may indeed hold out on

producing the lengthier, somewhat more concessive patient-centered responses, in the hopes that a patient may abandon their resistance first.

Of course, physicians do sometimes deliver a patient-centered response immediately, i.e., in response to the first instance of resistance (24%; n=17). The decision to respond immediately in a patient-centered way may be based on a number of factors, some of which may be purely clinical (e.g., a patient raised a concern that really does potentially change the diagnostic assessment), and many of which may not be observable using CA. The choice to immediately respond to resistance in a patient-centered way may also be shaped by personal preference, however there is not noteworthy variation among participating physicians in how often they do this, relative to the average 24%. (Note, however, that this sample of 5 physicians is likely not representative of the general population, as willingness to participate in the study may be shaped by a shared belief in the importance of communication in medical care.)

In some cases, the interactional context provides some clues as to why a physician does a patient-centered response right away. For instance, a diagnostic assessment may be so at odds with the patient's displayed concern, or there may be such extensive pushback against an impending diagnosis *before* the actual delivery of the diagnostic assessment that a brush-off or more physician-centered response would likely not result in the patient abandoning their resistance. In other cases, the form of resistance itself may make it difficult for a physician to respond in any other way. For instance, one patient questions her symptoms using a "how" question format – i.e., "How is X different from Y?" – which makes some kind of explanation conditionally relevant. These cases do not resolve the question of what drives physicians to immediately deliver more lengthy, somewhat concessive patient-centered responses more generally, but they do provide some clues as to the conditions under which they may reason that a more disattentive or physician-centered response may not suffice.

One further observation supporting the suggestion that physicians may generally reserve or hold out on patient-centered responses is that, as can be seen in the extract in the next section, in cases where there *is* a patient-centered response, there is usually *only* one. All other instances of resistance in a given series are typically met with responses that either brush them off or are physician-centered, both preceding and following the patient-centered response. This suggests a physician orientation toward patient-centered responses as *the* definitive effort to address patient concerns, not to be attempted twice. Notably, patients share this orientation, as their subsequent instances of resistance following a patient-centered response tend to be more off-record and easier to brush off (e.g., symptom descriptions) than those preceding patient-centered responses.

The data presented in these tables suggest that physicians may generally avoid the higher interactional cost of patient-centered responses by (1) responding to diagnosis resistance with brush-offs and physician-centered responses more often than patient-centered responses, and (2) reserving the more extensive patient-centered responses for specific clinico-interactional contexts, including more overt types of resistance and persistent resistance. One lingering question is: are patient-centered responses indeed more satisfactory to patients? That is, are they worth the cost once they are produced? I address this next by examining patient persistence qualitatively and quantitatively.

3.4.3 Patterns in Subsequent Patient Resistance

3.4.3.1 A Case Study of Patient Persistence

In cases of persistent resistance patients follow an initial instance of resistance with subsequent ones, pursuing more satisfactory uptake or response from the physician. Patients may pursue response locally or distally. Local pursuits sequentially occur immediately after some response to a prior instance of resistance, and more or less explicitly reject that response. These include both new discrete instances of resistance and what I described at the outset of this chapter as “bare”

pursuits. In contrast, distal pursuits occur at some distance from prior resistance, such that the patient locally accepted the physician's response but later resurrected their resistance via a new instance of resistance, sometimes from a slightly different angle. Subsequent patient resistance orients to the physician's prior response(s) as somehow inadequate in addressing their concerns. Consider Extract 15.

This extract revisits the patient from Extract 11, who suffers from an underlying chronic condition that makes him prone to muscle injuries like tears. He presents with swelling around his elbow that began some weeks ago when he heard and felt a “snap” and experienced pain when straightening his arm. In lines 1-6 the physician diagnoses the swelling as olecranon bursitis – swelling of a fluid-filled sac in the elbow – and a “superficial skin infection.” He rules out a joint infection. This diagnosis and rule-out addresses the pain and swelling in the elbow, but not the snap. The patient acknowledges the diagnosis with “I see” in line 7, then resists with “And the snap?” in line 10, a request for further diagnosis. The physician brushes off the resistance with a dismissive display of uncertainty in lines 12-13, “well who knows what the snap was” produced with laugh particles. This brush-off conveys that the physician didn't diagnose the snap because it's not diagnosable; the laugh particles and dismissiveness of “who knows” convey that establishing a diagnosis of the snap is irrelevant to the clinical task at hand.

(15) AMH 02-03 Diagnosis into counseling

1 DOC: It's probably a superficial thing, (.) u::h you probably
2 got a wh- you know olecrenon: uh- bursitis from fluid in
3 the joint there, .hh and then you probably got a little
4 superficial skin infection or somethin' I don't know. .h
5 'Cause if you had a joint infection: (.) I would expect
6 it to: (.) have been a lo:t more serious.
7 PAT: I see.
8 DOC: Yeah.
9 (0.5)
10 PAT: -> And the sna:p?
11 (0.2)
12 DOC: **.h Well the- who- who knows what the sn(h)a(h)p**
13 **[was.**
14 PAT: [eh heh heh.

15 DOC: Y'kno:w u:m
 16 (0.5)
 17 DOC: Y[- Y-
 18 PAT: -> [Well with me: it'[s like anything.
 19 DOC: [The pain ()-
 20 (0.5)
 21 **DOC: Yea:h. The pain in the elbo:w is (.) um (0.2) improving.**
 22 (1.0)
 23 **DOC: Right,**
 24 (0.5)

The patient takes up and affiliates with this with some laughter in line 14, but then pursues further response with another instance of resistance, “well with me it’s like anything” in line 18. This is an example of a local pursuit. As we find out later, this patient has an underlying condition that makes him prone to muscle tears, which the physician knows. Thus, this comment is a description of the patient’s illness experience that is produced as a contrast to the physician’s just-prior characterization of the snap as clinically irrelevant.

The physician begins his response to this new instance of resistance before the patient has finished, but after he has produced “well with me,” which conveys the thrust of the turn as disaffiliative (Heritage 2015). However, because the physician was already observably about to expand his prior response with “y’know” in line 15 and “y- y-” in line 17, coming in in overlap here gives the sense that he is not responding to this new instance of resistance *per se*, but merely continuing what he was already going to do (Schegloff 2000b). He drops out again, and once the patient completes his utterance he takes it up with a minimal “yeah,” then immediately shifts the topic (Jefferson 1984c, 1993), asserting that “the pain in the elbow is improving” in line 21. The response relevance of this utterance is ambiguous. On one hand it is in the patient’s domain and thus could be heard as a request for confirmation. But although the patient never explicitly said “the pain in my elbow is improving,” it could be gleaned from the illness narrative he told earlier in the visit; as such, it could also be heard as an account for the physician’s diagnostic assessment, including his decision that diagnosing the snap is clinically irrelevant. Indeed, the fuzziness of this

may be a resource, in that the physician is building an evidential case for his original assessment, while also asking a question in a way that could accountably be claimed as a return to investigation. The physician casts this as a request for confirmation by pursuing response with “right,” in line 23.

In response the patient says “I wouldn’t say it was the elbow” in line 25. This problematizes the physician’s understanding of the patient’s pain complaint as lodged within the elbow “per se” (line 27). It responds to both readings of the physician’s prior action, responding to the question but also contrasting with the physician’s characterization of his problem, thwarting the physician’s move to build a case in support of his original assessment and thus further resisting that assessment. This is another instance of a local pursuit, treating the physician’s just-prior responses as unsatisfactory. In response to this the physician returns to information-gathering by moving to re-examine the elbow in line 26, which he continues through the following 15 omitted lines. He completes the re-examination in lines 28-29, adding online commentary with “you’ve got pretty good strength there don’t you” in line 30 (Heritage & Stivers 1999). There is no explicit reassertion here. However, as with the physician’s actions thus far, it casts the problem as no problem and further works to build a case in support of the original assessment, that diagnosing the snap is not clinically relevant.

21 DOC: Yea:h. The pain in the elbo:w is (.) um (0.2) improving.
 22 (1.0)
 23 DOC: Right,
 24 (0.5)
 25 PAT: -> .h I wouldn't say it was the elbow.
 26 (0.2) ((DOC moves to re-examine))
 27 PAT: -> Uh per se:,
 ((15 lines omitted; more physical exam of elbow))
 28 DOC: °(Good.)° No:w push against my hand,
 29 (1.8)
 30 DOC: You've got pretty good strength there. don't you.
 31 PAT: -> Yeah the str[ength is back now.
 32 DOC: [°Pull,°
 33 (1.0)
 34 DOC: >Yeah .h< Let me just check and make sure there's
 35 nothing in there.=Oka:y,
 ((lines omitted; 15 minutes of other talk and doc puts
 needle in patient’s elbow, finding fluid))

The patient somewhat covertly pushes back against this no-problem characterization by

agreeing that “yeah the strength is back” but adding “now,” which implies that he had lost strength in his elbow the first place (Raymond 2003). In overlap with this the physician does one final physical exam move with “pull,” in line 32, and then merely says “yeah” in line 34. One hearing of this “yeah” is as a minimal acknowledgement of the patient’s turn. However, given the physical exam move overlapping that turn, it can also be heard as a confirmation that the findings from the exam support his assessment that he has “pretty good strength there”; it thus deletes or at the very least ignores the patient’s resistant response. The physician then moves immediately into what he said he was going to do earlier – put a needle in the patient’s arm to check for fluid. By doing more investigation – in particular, investigation that is observably done to support the original assessment – but without revisiting the assessment at the end and just returning to his original agenda, the physician does not actually address patient concerns, but rather prioritizes his original assessment and his own agenda. For the following 15 minutes he engages in the needle procedure, during which they talk about other areas of the patient’s life and health. The patient’s resisted project is thus seemingly abandoned.

However, as the physician is wrapping up his procedure, having commented that there was indeed fluid in the elbow (consistent with a diagnosis of olecranon bursitis), the patient asks, “you think the fluid and all this the trauma came from somewhere else?” in lines 36-37. On its face, by topicalizing the fluid in his elbow, this question focuses on the physician’s current project. However, the stress on “somewhere else” contrasts with the snap, and thus implicitly returns to the patient’s original concern and prior diagnosis resistance project. This is an example of a distal pursuit of a more sufficient response to the patient’s resistance, as it occurs at some distance from the prior instances of resistance.

36 PAT: -> You think the fl- fluid and all this the trauma came
37 -> from somewheres else?
38 DOC: Um.
39 PAT: Bec[ause-

40 DOC: [Sorry ((nurse name)),
41 NUR: [That's okay,
42 PAT: -> [You know what I mean?
43 DOC: Um. I don't think so. I think it was probably from when
44 you heard that noise.
45 (1.2)
46 PAT: -> [Oka:y,
47 DOC: [Probably (when)-
48 (0.8)
49 DOC: U[m.
50 PAT: -> [A- And I would lose strength like tha:t?
51 DOC: .pt .h Yeah.

The physician is engaging with the nurse in line 40, and the patient pursues response in line 42 with “you know what I mean?” The physician responds with “I don’t think so. I think it was probably from when you heard that noise” in lines 43-44. Here again he refuses to clinically expand on the snap, even avoiding the word “snap” and referring to it as “that noise” instead. After a 1.2-second silence, the patient responds with a rising-intoned “okay” in line 46, treating the physician’s response as insufficient and pursuing elaboration, although it is not a new, discrete instance of resistance. This is an example of a bare pursuit.

The physician begins to respond with “probably when-” in line 47, and “um” in line 49, but before he can continue the patient adds “and I would lose strength like that?” Here he revisits his concern about the loss of strength, alluded to in his prior “yeah the strength is back now” as analyzed above. This is a further instance of resistance – a question about the “fit” of some symptom(s) with the diagnostic assessment that indeed challenges that fit – that constitutes a local pursuit. The physician answers with “yeah,” a minimal answer to the question that does nothing to address the concerns potentially underlying the question – which is becoming particularly noteworthy given the context of persistent resistance, and the fact that it is fairly clear what the patient’s concern is about.

The patient responds with another rising-intoned “okay” in line 52, another instance of a bare pursuit treating this response as insufficient. This is when – after the patient’s 8th resistant move

– the physician finally does a somewhat patient-centered response that aligns with the patient’s project. Turning to fully face the patient, he diagnostically expands on the snap using clinical terminology to describe a tear, “you may have avulsed a part of the tendon from the bone” in lines 54-55, and then connects this to the patient’s experience – and indeed the locus of the patient’s concern – with “maybe that’s why it popped” in line 57.

50 PAT: -> [A- And I would lose strength like tha:t?
51 DOC: .pt .h Yeah.
52 PAT: -> Okay,
53 (1.0)
54 DOC: .hh Well I think=hh I think you may have avulsed (0.5)
55 um (0.2) a part of the tendon y'know from the bo:ne,
56 (0.5)
57 DOC: Maybe that's why it popped,
58 PAT: It- it d- it came off?
59 (0.8)
60 DOC: Maybe a small part of it did?='Cause you got too mu- (0.2)
61 .h your strength's too good right now y'know for you to
62 have lost- you didn't use- lose the whole te[ndon.
63 PAT: [Yeah well I
64 got you. Tear: [a tear.
65 DOC: [() You might've torn away a little bit.
66 PAT: Oh gee[z.
67 DOC: [An-
68 (0.2)
69 PAT: I'll tell you about tears.
70 DOC: I know right,
71 PAT: Holy god.
72 DOC: Um. ((to NUR)) He has a condition that predisposes him to injury,
73 NUR: °(Mm hm, Kay.)°
74 PAT: I got- I got two more tears.

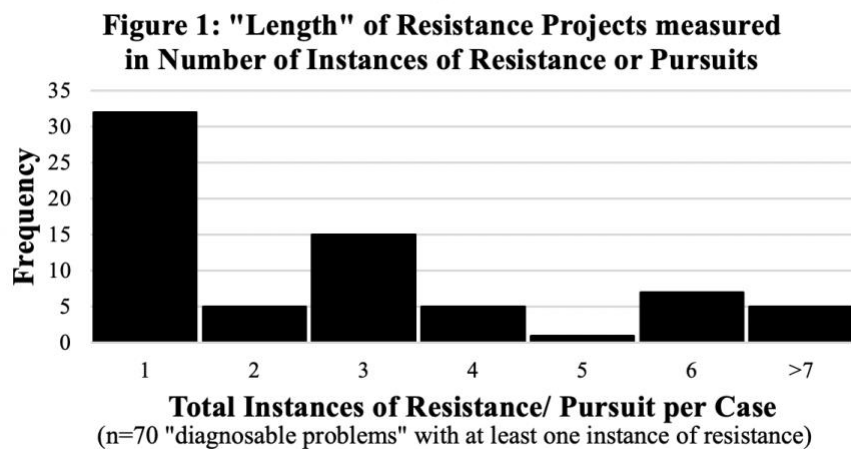
The patient proffers a candidate understanding with “it came off?” in line 58, which the physician confirms with “maybe a small part of it did?” in line 60, followed by an evidential account for this assessment. The patient both claims and demonstrates understanding in lines 63-64 with “yeah well I got you. Tear, a tear.” When the physician confirms his understanding of this diagnosis as a “tear” in line 65 (“you might’ve torn away a little bit”), the patient responds emotively with “oh geez” in line 66 and “I’ll tell you about tears” in line 69. This indeed reveals the concern underlying his resistance the whole time – he is prone to tears, has had many, is worried about more, and was concerned all along that this problem was another one. There is no further resistance in this visit,

and the patient thus treats this response as satisfactory. In other cases of persistent resistance, especially those without a patient-centered response, the patient's abandonment of their resistant project is hearable more as a decision not to continue pursuing, rather than a true orientation to the physician's response as satisfactory.

This extract illustrates the extent to which patients may, and often do, persist in their diagnosis resistance, locally and distally, seeking a response that more satisfactorily addresses their concerns than the responses-so-far.

3.4.3.2 Patterning of Persistent Resistance

Across the 70 counseling phases for diagnosable problems with at least one instance of resistance, 38 (54%) contain at least one pursuit beyond the first instance of resistance. The average number of instances of resistance per case, including all pursuits, is 2.9 with a standard deviation of 2.6. The modal frequency of instances is 1, the median is 2, and the longest case is made up of 16 instances. Figure 1 shows a histogram of the "length" of resistant projects across these 70 cases, measured in total number of instances of resistance or pursuit.



These numbers suggest that, from the patient's perspective, physicians are often not responding to diagnosis resistance in a way that sufficiently addresses their concerns. From the physician's perspective, these numbers illustrate the interactional challenge physicians sometimes

face in primary care visits for new or acute problems, when they are presented with instance after instance of a patient working to reverse progressivity of the visit, renewing the relevance of information-gathering or diagnostic inquiry, and thus challenging the physician’s authority to have assessed the patient’s problem and moved on to counseling in the first place.

The remaining two tables show patterns of patient persistence relative to physician response type. The unit of analysis for these tables is individual physician responses to discrete instances of resistance. Table 8 compares how often patients pursue response in any way versus abandon their resistant project following the three categories of physician response. As the “Totals” column of this table shows, patients are generally more likely to pursue a more satisfactory response (68% of the time) than to abandon their resistance across all three response types, suggesting that physician responses *in general* are not satisfactory.

However, patients pursue brush-off responses significantly more than the other two responses (77% vs. 58% and 56%; $p < .05$). This suggests, unsurprisingly, that these types of responses are the least sufficient in patients’ eyes, or at the very least that they’re least willing to *treat* such responses as sufficient by abandoning their resistance. It also provides further support of the argument that even the types of resistance that look the least *like* resistance – i.e., those patient-domain actions that physicians are most likely to brush off – did indeed indicate lingering patient concern(s) that physicians are not addressing in their responses. Thus, although brush-offs may afford the fastest return to the physician’s own interactional agenda, more often than not they likely end up spending *more* time – and dealing with a greater threat to their authority – as a result of subsequent instances of resistance.

Table 8
Distribution of pursuits across response categories – *N* (%)

Brush off	Physician-centered	Patient-centered	Totals
-----------	--------------------	------------------	--------

Subsequent pursuit	78 (77%)	33 (58%)	22 (56%)	133 (68%)
No pursuit	23 (23%)	24 (42%)	17 (44%)	64 (32%)
Totals	101 (100%)	57 (100%)	39 (100%)	197 (100%)

$p < .05$

$n=197 \rightarrow$ 177 response slots following discrete instances of resistance (6 cases omitted because patients obscured the response slot and moved on) + 20 slots following bare pursuits (see Data section)

Breaking down patient pursuits into local and distal reveals more on this. As Table 9 shows, in general, the majority of pursuits are local (71%) rather than distal.

Table 9

Distribution of local vs. distal pursuits across response categories – N (%)

	Brush off	Physician-centered	Patient-centered	Totals
Local pursuit	60 (77%)	20 (61%)	14 (64%)	94 (71%)
Distal pursuit	18 (23%)	13 (39%)	8 (36%)	39 (29%)
Totals	78 (100%)	33 (100%)	22 (100%)	133 (100%)

Table 9 also shows that patients are pursuing locally at a slightly higher rate following brush-off responses (77%) than following responses that attend to their resistance (physician-centered responses 61%; patient-centered responses 64%). This may further reflect a greater dissatisfaction with brush-off responses than with more attentive ones. However, it may also suggest that, when physicians *do* attend to their resistance, whether in a physician-centered or patient-centered way, it is more interactionally difficult to immediately resist again without coming off as combative or argumentative. When physicians brush off patient responses, it may be easier to resist again immediately because the brush-off response neglected to acknowledge that the prior turn was resistant to begin with. The reduced rate of local pursuits relative to distal pursuits with physician- and patient-centered responses may reflect patients' reduced willingness to directly challenge the physician's response, and to instead resurrect their resistance – often from a slightly new angle – when another opportunity presents itself.

Somewhat surprisingly, patients persist in their resistance following patient-centered responses at a similar rate as they do following physician-centered responses (Table 8), and their pursuits are similarly distributed between local and distal pursuits in both cases (Table 9). This is the case regardless of whether the physician's patient-centered response aligns or disaligns with the patient's resistant action. This finding is more perplexing. It may be the case that patients find even patient-centered responses to their resistance unsatisfactory. Further analysis is needed to unpack the ways in which these responses still neglect to address patient concerns, but one area that could potentially be improved is the extent to which physicians *query* patients about their concerns. Indeed, the "patient-centered" responses in the data are coded as such because of how physicians observably put their own agenda on hold in order to address patient concerns. However, this mostly consists of, e.g., investigating symptoms from a clinical perspective, delivering additional diagnostic information, or explaining the evidential basis for a diagnosis. Physicians rarely ask patients about *their* concerns, and even the most "patient-centered" responses may not be sufficient in patients' eyes.

In sum, the foregoing distributions and patterns of response types suggest the following: (1) when faced with patient resistance of their diagnostic assessment, physicians prioritize their original assessment, their own clinical agenda, and maintain progressivity toward visit closing; and (2) patients treat physicians' responses to their resistance as insufficient through persistent – sometimes rather extensive – resistance. As discussed in Chapter 2, the sheer frequency of diagnosis resistance in the first place suggests that patient concerns about their condition or its assessment more often than not are being inadequately addressed. What the current chapter suggests is that once lingering patient concerns emerge as diagnosis resistance, things get worse from there, as physicians attempt to maintain clinical and interactional authority, and patients are left in the interactionally difficult, and perhaps for some distressing, situation of either persisting with resistant actions that implicitly challenge that authority or abandoning their project and leaving without having had their concerns

fully addressed.

DISCUSSION

Regardless of patients' underlying motivations for resisting accepting or going along with a physician's diagnostic assessment, by interrupting counseling to make a move to an activity context where the physician's assessment may still be shaped, they implicitly challenge physicians' interactional authority to have moved into counseling, as well as their epistemic authority to have assessed the problem in the first place. Diagnosis resistance also creates a response slot where reconsideration of the patient's problem, reassertion of the original assessment, or at least pursuit of the patient's concerns underlying their resistance is at least potentially relevant before resuming counseling activities. This move backward is happening in a context where physicians have limited time to spend with each patient and have already begun an observable move toward closing the visit.

In the foregoing analysis I illustrated three main ways physicians respond to diagnosis resistance. With the first type, which I've termed brush-offs, there is no engagement with the resistance embodied in the patient's prior turn. Patient turns are ignored, minimally acknowledged, or not treated as resistant actions. These actions typically afford the fastest return to the physician's interactional agenda. The remaining types of responses to resistance *do* acknowledge resistance, and deal with it in either a physician-centered or patient-centered way. With physician-centered responses, physicians observably work to move past the resistance and return to their clinical agenda as quickly as possible. With patient-centered responses, they work more expansively to acknowledge or address patient concerns before moving on.

The data suggest that physicians tend to avoid the lengthier and somewhat more concessive patient-centered responses. We can see this in how physicians produce patient-centered responses in less than a quarter of cases; often wait to produce them until a patient has resisted multiple times;

and rarely produce more than one in a visit. Instead of unpacking and attending to patient concerns, physicians appear to prioritize getting back to their clinical agenda and restoring progressivity toward visit closing as quickly as possible. We can see this in how physicians produce brush-offs a full half of the time and how, when they do acknowledge a patient's resistance, they respond to it in a more physician-centered way three-fifths of the time.

There are two potentially relevant social forces at work here: time and medical authority. I propose that the constraints of the former may in part be shaping the evolution of the latter in primary care, and that brush-offs may represent a mechanism in that evolution.

Patient-centered care generally takes more time interactionally and cedes some medical authority. These two features are deeply intertwined. By its very nature, seeking the patient's perspective on a medical issue cedes authority, as does persuasive explanation; as Starr (1982) puts it, authority "signifies a potential to use force or persuasion, though paradoxically authority ends when either of these is openly employed." Omitting such interactional work may shorten the time it takes to respond to diagnosis resistance, but it also makes the response less patient-centered and more paternalistic. For instance, toward the more paternalistic end of Byrne and Long's (1976) cline of diagnostic utterances are statements that give minimal information, direct patients toward some treatment, and move to close the visit, e.g., "You seem to have nothing more than a bout of influenza. Take this to the chemist on your way home..." (p. 106). In Byrne and Long's data, paternalistic diagnoses were the most common. However, more recent conversation analytic work suggests that physicians are actually holding themselves more accountable to patients for their diagnostic reasoning, doing work leading up to and during diagnosis delivery to explain, account for, or otherwise provide insight into their diagnostic assessment (Peräkylä 1998; Heritage & Stivers 1999). In a context where physicians and patients may already have divergent orientations toward the relative importance of diagnosis in primary care (Green & Holden 2003; Heneghan et al. 2009;

Heritage & McArthur 2019), this extra work – and its concomitant erosion of traditional epistemic authority – may be one reason physicians only actually deliver ‘official’ diagnoses around half the time (Heritage & McArthur 2019).

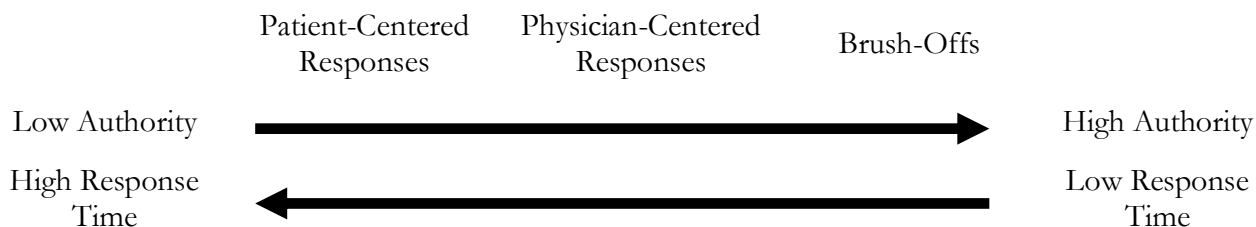
Whereas overbuilt diagnoses may be delivered in part to stave off resistance, once diagnosis resistance has emerged, physician accountability may be even more salient in contexts where the physician maintains or reasserts their original, resisted diagnostic assessment. Indeed, in my data there are no “bald” reassertions of diagnostic assessments; when they are not elided or framed in a way that incorporates the patient’s resistance, explicit reassertions invariably include some form of persuasive or explanatory practices. While such explanations do assert some degree of epistemic authority over the matters explained, they simultaneously temper this authority with accountability for the diagnosis (Peräkylä 1998). But all of this accountability work means reasserting the diagnostic assessment – and, more broadly, engaging with patient resistance in the first place – is more costly in terms of progressivity.

This is where brush-offs come in. By displaying an understanding of the patient’s turn as non-resistant, physicians neither legitimize the underlying threat to their authority, nor cede any authority through persuasion or explanation; and they return to their clinical agenda, restoring progressivity faster than even with physician-centered responses. Responses that brush off a patient’s resistance may in a way be the most paternalistic way a physician can respond. But rather than asserting medical authority, such responses assert interactional authority – which is itself rooted in their medical authority in society – to drive the progression and direction of the clinical encounter. Patients defer to this authority when they obscure or mitigate their resistance, making it easier to brush off their concerns and maintain visit progressivity; and physicians enact it when they indeed treat a turn as non-resistant and return to their own agenda.

When viewing brush-offs in this way, we can see the three response types sitting along a

cline, such that the less time it takes to produce a response and move on, the more authoritative that response type is, and vice versa. See Figure 2.

Figure 2: Relationship between authority and response time in physician responses to resistance



Patient-centered responses take the most amount of time and cede the most amount of authority, as physicians do work to take patient suggestions into consideration, explain their reasoning, and generally present their reasoning as accountable to the patient’s theory of the illness. In contrast, physician-centered responses take less time and are more assertive of authority, whether more interactional (e.g., the physician does more history-taking and then moves on without comment) or clinical (e.g., perfunctory persuasion). On their surface, brush-offs don’t deal with authority at all. Nonetheless, physicians are exercising their interactional authority, based in medical authority, to treat the patient’s turn as non-resistant and return to their own clinical agenda. These take the least amount of response time.

On one hand, physicians may be driven toward more paternalistic responses out of a desire to protect their medical authority or push back against a patient’s attempted breach of that authority, especially in the context of resistance toward a diagnosis *per se*. This would align with much earlier findings that, in general, physicians maintain a biomedical focus even in contexts where patients reveal concerns underlying their health problem, or other aspects of their lifeworld perspective (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992). However, given the intense constraints – real and perceived – on physicians’ time, especially in primary care, physicians may also be motivated to produce more paternalistic responses because they don’t feel they have time to do something

more patient-centered. In this case, the assertion of medical authority in the face of diagnosis resistance may be in part *shaped* by the time constraints of the healthcare system.

In this context, even physicians who consider themselves excellent communicators and proponents of patient-centered care may find themselves behaving in a more paternalistic way. Indeed, on the 9-question “Sharing” sub-scale of Krupat et al.’s (2000) Physician-Patient Orientation Scale, which measures the extent to which physicians “believe that patients desire information and should be part of the decision-making process” (p. 51), all five participating physicians in this study rated high, or patient-centered, with a score of greater than 4.0 out of 5 when measuring the mean of all questions answered on a five-point Likert scale. Nonetheless, in the data, all five physicians are generally avoidant of the more patient-centered ways of responding to diagnosis resistance.

Considering this behavior of individual physicians at scale, across all primary care physicians, this seemingly insignificant interactional process has repercussions for healthcare and medical authority at large. For one, the ways physicians are brushing off patient concerns in the face of diagnosis resistance may be one empirical illustration of what Braddock and Snyder (2005) worried might result from physician perceptions of inadequate time with patients – that it would “cause physicians to forego activities and behaviors that promote important aspects of the patient-physician relationship.” More broadly, this interactional process may be part of a more macro-level social process whereby institutional constraints – here, time – are in part shaping the expression and evolution of medical authority in primary care.

Stivers and Timmermans (2020) and others (Cutler 2004; Levinson et al. 2005) suggest that medical authority is not experiencing the steep and unending decline, precipitated by countervailing forces like patient-centered care, once predicted by medical sociologists (e.g., Light 2010). Rather, they argue that although patients’ “ability to shape the medical encounter is robust in the domain of treatment recommendations where there is shared orientation to patients having a normative

obligation to endorse a treatment recommendation” (p. 4), physicians have generally retained epistemic authority over issues like diagnosis. The current study adds some nuance to this picture in primary care.

On one hand, the mainly off-record ways patients resist diagnoses displays a strong orientation to physicians’ authority over diagnosis. But the mere frequency of diagnosis resistance in my data suggest that even physicians’ epistemic authority over diagnosis is “under siege” in primary care (Stivers & Timmermans 2020). However, where physicians may cede some of their authority via negotiation and practices for persuasion and shared decision-making in the context of treatment, my data show that the same is not true for diagnosis. On one hand, physicians’ general display of reassertions as accountable does suggest some orientation toward a tempering of the all-powerful medical authority described by, e.g., Byrne and Long (1976). Yet physicians are far more often engaging in a somewhat novel (or at least newly described) interactional strategy – brush-offs – that allow them to avoid engaging with or acknowledging resistance at all, preserving, at least on the surface, their epistemic primacy and authority over diagnosis. These kinds of responses may at least in part be shaped by institutional constraints and afforded by the fact that patients themselves resist most often in ways that allow physicians to ignore or otherwise brush them off.

There is almost a sense of collusion between patients and physicians to keep diagnosis resistance off-record and to protect the progressivity of the visit from being too compromised by it. We may be in a liminal state for medical authority in society, at least in primary care, where patients are more engaged (Timmermans 2020) and thus more likely to reason about their problems diagnostically and push to get their concerns addressed, yet they are undermining their own efforts by orienting to the minimal rights they have to indeed push back. And although an increasing push for patient-centered care would see physicians pursuing, discovering, and addressing patient concerns – even about diagnosis (Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower

2002; Epstein et al. 2005b; Illingworth 2010; Silverman, Kurtz & Draper 2013) – this is not what physicians are doing in practice. More research is needed to examine how these practices are influenced by broader norms and institutional constraints in primary care; how and whether the practices examined in this chapter may reflect a liminal state in the decline of medical authority in this specific medical specialty; and why.

CHAPTER 4:

Contexts of resistance: Divergence and unaddressed patient concerns

4.1 INTRODUCTION

As I have shown, diagnosis resistance presents social and interactional challenges for both physicians and patients in primary care. For physicians, resistance presents an implicit challenge to their medical authority and risks undermining their normative role in addressing patients' health problems. Resistance may also be difficult to address once it arises, especially in a context where physicians have limited time to spend with each patient. This is because diagnosis resistance, by its definition, initiates reversal of the progressivity of the visit, making a move to an activity context where the physician's assessment may still be shaped. Patients indeed orient to this as a risky endeavor, relying primarily on resistant actions in their own domain that place the least amount of pressure on physicians to respond, orienting to the physician's medical authority but also undermining their own efforts to raise lingering concerns about their condition or its assessment. When physicians respond in ways that indeed prioritize their own their own clinical agenda, patient concerns remain unaddressed.

Primary care represents the first contact most people have with the healthcare system regarding some new, unknown symptom(s). Physicians presented with new health problems are often the first (and sometimes only) person to define a patient's health condition, and they are the gatekeepers to diagnostic tests, referrals to specialized care, and treatment. How acute care visits in this setting unfold can set the tone and trajectory of care for that problem and can also influence whether and how patients interact with the healthcare system in the future (Shi 2012). That patients may be resisting physicians' diagnoses in as many as four fifths of acute care visits, and that their concerns are not subsequently being met, reflects a potentially pervasive problem in the delivery of

primary care in the US more generally. In this chapter I ask: what are the interactional processes leading patients to resist physicians' diagnostic assessments, both in individual visits and across primary care visits more generally?

So far in this dissertation my analyses have looked at moments of resistance and their interactional sequelae in the visits where they occur. But resistance doesn't merely *present* problems for physicians and patients, it *reflects* problems in the visit-so-far. Using conversation analysis to examine the wider interactional context of acute care visits – i.e., what happens *before* possible moments of resistance – I identify commonalities among cases where resistance occurs, and contrast these with cases where it does not. I argue that diagnosis resistance occurs in cases where there is observable *divergence* between patients' and physicians' assessment of the patient's problem.

Patients arrive at the doctor's office having already assessed their problem to some extent: whether it merits medical attention, their feelings about it, whether and why it's worrisome, ideas about what is wrong, expectations from the doctor, and so on (Illingworth 2010). Although patients' "true" underlying concerns are not accessible, some aspects of their assessment are rendered observable in how they present and talk about their problem in the early phases of a clinical encounter. In some cases, they may be explicit, for example by requesting a particular treatment or test, or by suggesting a candidate diagnosis. In other cases, patients more subtly convey aspects of their assessment in the way they frame and describe their symptoms. As physicians investigate and assess patients' problems, their assessment may observably diverge from how the patient presented the problem. Once counseling begins and the physician's assessment is no longer ostensibly under development, divergence solidifies into a gap between patient concerns and how the physician is addressing them, which will persist through visit closing absent some move to reopen assessment activities. It is out of this gap that I argue diagnosis resistance emerges.

In contrast, visits where patients do not resist are characterized by convergence between

patients' and physicians' assessment of the patient's problem. This finding suggests that patient resistance can only be mitigated when, to put it unceremoniously, patients get what they want or their theories are confirmed. There are, however, a small subset of cases where there *is* observable divergence but no later resistance; in these cases, physicians have done work to bridge the gap by explaining their clinical reasoning in a way that ties to the patient's concerns. This may point to one way physicians can mitigate resistance even in contexts of divergence.

Primary care is a context where a strong doctor-patient relationship is seen as therapeutic and a fundamental part of medical practice. But, especially in acute care contexts, a purely biomedical perspective often prevails (Mishler 1984). Taken together, the findings from this chapter point toward a recommendation patient-centered care scholars have been making for years: that physicians should actively pursue and address not only the biomedical aspect of a problem, but also the patient's perspective, including their expectations, feelings, theories, and concerns about that problem (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992; Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Mishler 2005; Illingworth 2010; Silverman, Kurtz & Draper 2013). Such recommendations still remain more of an aspiration than a clinical reality (Timmermans 2020), which some attribute to an underdeveloped evidence base for patient-centered care relative to, e.g., evidence-based medicine (Bensing 2000). The findings from this chapter suggest that unaddressed patient concerns may indeed be a pervasive problem in primary care, and that further empirical inquiry into the patient-centered approach of actively pursuing and addressing the patient's perspective may be the best first step in improving this aspect of patient care.

4.2 BACKGROUND

4.2.1 *The Social and Interactional Context of Diagnosis Resistance*

To understand the processes leading patients to resist diagnostic assessments in primary care, it's necessary to consider the particular social and interactional context within which their medical complaints are investigated and assessed. There is widespread acknowledgment among healthcare providers and researchers of healthcare delivery, spurred by the patient-centered care movement, that a necessary element in providing adequate care is to uncover the patient's perspective on their own condition – including, for example, their feelings about the problem, ideas about what is wrong, the effect of their symptoms on their functionality, and their expectations from the doctor (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992; Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Mishler 2005; Illingworth 2010; Silverman, Kurtz & Draper 2013).

However, this is not typically what happens in primary care visits for new or acute health problems. This institutional context is instead characterized by behavior – both physicians' and patients' – upholding a legacy of normative epistemic and interactional asymmetries between the roles of physician and patient. Participants' normative orientations toward physicians as the drivers of the investigation of a patient's problem, and toward their mainly biomedical and disease-oriented perspective as dominant, means that patients have few opportunities to express their perspective on their condition, and physicians rarely pursue it.

This is not to say patients have *no* opportunity to communicate their perspective. Indeed, as many conversation analysts point out, the problem presentation phase of the visit is a dedicated space for patients to describe their problems or tell their illness narratives in their own words (e.g., Stivers 2007; Robinson 2003; Heritage & Robinson 2006a,b). And despite studies from other areas of doctor-patient communication research suggesting that physicians often “interrupt” patients,

cutting off their opportunity to fully tell their story (e.g., Beckman & Frankel 1984), the conversation analytic method has revealed that the transition from patient problem presentation to physician information-gathering is a much more finely tuned process, and that patients in most cases signal their readiness for physicians to take over (Heritage & Clayman 2010).

But despite this relatively unconstrained space for patients to reveal their perspectives about their problem, they typically maintain a normative orientation toward the biomedical perspective and a “symptoms only” telling of their problem (Stivers 2002a), and physicians typically focus on the biomedical implications of patients’ contributions even when patients reveal some aspects of their lifeworld concerns (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992). Even when physicians do attempt to solicit a patient’s perspective, patients typically defer to the physician to determine what’s most relevant (Thorsen et al. 2001).

Explicit requests, e.g., for a particular treatment or diagnostic test, do happen, but they are rare. More often, when patients work to reveal some particular expectation, worry, or causal theory about their problem, they do so in somewhat covert ways. Patients may, for instance, request specific outcomes obliquely by hinting at candidate diagnoses, fears, risk factors, etc. (Gill, Halkowski & Roberts 2001). In cases where they may expect or hope for a particular treatment like antibiotics in particular, patients may display their expectations by, for example, mentioning a candidate diagnosis of a bacterial infection during their problem presentation (Stivers 2002a, 2007), which implies rather than directly requests a treatment recommendation of antibiotics. In other cases, patients are even more covert, describing “diagnosis implicative symptoms,” e.g., green nasal discharge, which suggest a candidate diagnosis without stating one (Stivers 2002a; Filipetto et al. 2008). Or patients may push a physician toward or away from a particular line of diagnostic inquiry by raising a candidate explanation for their problem and then reporting symptoms or circumstances that undermine or work to rule out that explanation (Gill, Pomerantz & Denvir 2010). Some of

these and other practices for negotiating a physician's assessment of a patient's condition can also be accomplished during history-taking and physical examination phases, albeit while simultaneously dealing with the interactional constraints of a question-answer sequential context (e.g., "answering more than the question" during history-taking; Stivers & Heritage 2001; Stivers 2007).

Through these practices for revealing their perspective on their problem, or for shaping the physician's assessment, patients maintain an orientation to the physician's epistemic authority over clinical reasoning, and to the primacy of the biomedical perspective in the medical encounter. These practices can be thought of as "trial balloons" patients send out and then wait to see how the physician will respond or take them up during the physician's subsequent information-gathering and assessment. The problem is, when a physician's assessment diverges from the patient's and the visit then moves into counseling, patients may be left in a sort of "now or never" interactional space for getting their concerns addressed (White, Levinson & Roter 1994; White et al. 1997), leading to the diagnosis resistance described in this dissertation.

4.2.2 Lines of Divergence

In this section I synthesize what's been said in the existing literature on patient concerns and diagnosis resistance, focusing on three main aspects of a patient's assessment from which a physician's assessment may diverge: expectations for a particular outcome; theories of the illness; and the doctorability of the problem. It's important to note that these lines of divergence are neither exhaustive nor mutually exclusive; this categorization is merely intended to lay the groundwork for understanding some of the reasons patients may ultimately resist a diagnosis; indeed, there is much overlap between these conceptually and in the data.

4.2.2.1 Patient Expectations

In his review of the literature on patient expectations, Kravitz (1996) notes a few important dimensions of the term. Expectations may be probability-based, as in a patient's expectation of the likelihood that something will happen during their visit, or they may be value-based, as in a patient's hope or desire for a certain clinical event. Most expectations have to do with the "process" aspect of medical care, as in what the provider actually does during a visit – information-gathering, testing, prescription, etc. – but may also include expectations about the institution and staff, as well as longer-term outcomes like "I will get better." Even process-oriented expectations, though they may be well-formed as in "I want an antibiotic," may be more amorphous as in "I hope the doctor shows interest in my problem and tries hard to solve it" (p. 12). In general, reviews of the literature on patient expectations agree that there is not enough consensus on what is meant by the term or how to measure it (e.g., Kravitz 1996; Thorsen et al. 2001). This may indeed be because patient expectations are so multifaceted and sometimes amorphous for patients themselves.

Many studies that attempt to measure patient expectations and determine whether they were met focus, unsurprisingly, on more tangible and thus more easily measured outcomes like diagnosis, prognosis, prescriptions, tests, and referrals (e.g., Jackson & Kroenke 2001). These studies find that patient expectations are often unmet, and that this leads to lower patient *and* physician satisfaction with the visit (Jackson & Kroenke 2001; Hooper et al. 2005). Moreover, Hooper and colleagues (2005) have found that physicians and patients often don't even agree on *whether* patient expectations were met, even when those expectations are spelled out explicitly.

In conversation analytic studies, patients can be seen pushing for particular clinical outcomes via an interactional 'project,' which typically extends beyond single actions or sequences, and can be seen to shape a participant's interactional moves, both overt (e.g., requests) and more implicit (e.g., turn design). In the literature on interaction in medical settings, the most often discussed outcome

that a patient may work toward is treatment – specifically, antibiotics in the context of upper respiratory infections (e.g., Heritage & Stivers 1999; Stivers 2002a, 2005, 2007; Heritage et al. 2010). Other patient projects include referrals to specialists and diagnostic tests (e.g., Gill, Halkowski & Roberts 2001), which patients may push for by explicitly requesting or mentioning them (e.g., “I thought you might refer me to a dermatologist”), or by pushing for a candidate diagnosis that might indicate them. Patients have indeed been shown to resist diagnostic assessment that depart from patients’ expectations (Stivers 2007; Ijäs-Kallio, Ruusuvoori and Peräkylä 2010).

Notably, patients’ ideas about which illnesses indicate which outcomes may be inaccurate from a clinical standpoint. For example, many patients believe that x-rays, which cannot image anything in the soft tissue, can be used for a wider range of problems than those for which they are clinically indicated, such as muscle strains or tears (Makanjee, Hoffmann & Bergh 2015). Moreover, patients’ projects, even when they include explicit mentions of a specific outcome like an x-ray, may not be for *that* outcome in particular, but more generally for any outcome that would accomplish something similar. For instance, patients may be satisfied with procedures or prescriptions that are just as ‘curative’ as they perceive antibiotics to be. Or, in the case of x-rays, patients may simply want, as one patient puts it in the AMH dataset, “something that can look inside.” In any case, the point is that patients often do work early in visits to push a physician toward one outcome or another, and that work makes their project visible, even in the absence of explicit requests (Gill, Halkowski & Roberts 2001).

Related to these projects, but less discussed in the literature, is when a patient displays some orientation to an expectation for a diagnosis. Studies suggest that, despite the supposed centrality of diagnosis in the practice of medicine, primary care is a unique setting where a precise diagnosis is not always possible and is not always treated by physicians as necessary. In this setting, there is a relatively high rate of symptomatic discomfort and a relatively low rate of serious illness (Heneghan

et al. 2009). Symptoms are often underdeveloped or ambiguous, and even in cases where further testing may be able to establish a diagnosis, treating the condition may not require an exact diagnosis (Green & Holden 2003; Heneghan et al. 2009; Silverston 2016). In cases where more serious illness is suspected, primary care physicians' main role is to either rule out serious illness, or refer patients to a specialty physician, e.g., a cardiologist, whose job it is to establish a more precise diagnosis (Heneghan et al. 2009). In cases where serious illness is ruled out, again, establishing an exact cause of a patient's (now non-serious or life threatening) symptoms may not be seen as necessary.

Heritage and McArthur (2019) have shown how diagnosis is indeed devalored by physicians in primary care encounters, with physicians 'officially' diagnosing a problem only half the time (PCT dataset), opting in other cases to move straight to treatment, or to discuss diagnostic uncertainty and *then* move straight to treatment, orienting to that uncertainty as acceptable and unnecessary to resolve. Such behavior emerges in the AMH dataset as well. But other studies suggest that primary care patients do expect a diagnosis of their problem (Korsch, Gozzi & Francis 1968; Novack 1987; Jackson & Kroenke 2001; Jackson 2005; Ruiz-Moral et al. 2007). Thus, despite studies suggesting that patients in general align with physicians' devalorization of diagnoses by declining to immediately respond to them (Heath 1992; Peräkylä 2002, 2006; Stivers 2007; Koenig 2011), this underlying difference in attitudes may be one driver of diagnosis resistance, alongside other cases where patient expectations are not met.

4.2.2.2 Theories of the Illness

From the moment a patient experiences some new symptom onset, they begin working to make sense of it – what it is, what caused it, how bad it is, whether it is indicative of serious illness, what to do about it, and so on (Benyamini 2018). The ways patients make sense of their symptoms are shaped by their own past illness experiences, interactions with the healthcare system, the

opinions of those around them, their culture, gender, age, and education etc., and their emotions surrounding the symptom, e.g., fear, frustration and so on (Benyamini 2018), and their experiences of marginalization (Mishler 2005). In turn, patients' beliefs and theories surrounding their symptoms shape their decision to go to the doctor in the first place, and underly their expectations when they get there. Moreover, patients' beliefs influence how they understand what a physician tells them about their condition. Greater discrepancies between a patient's beliefs and what their doctor tells them may lead to a greater likelihood that the patient will distrust the physician's assessment and continue to seek alternate explanations or assessments (Benyamini 2018).

The most straightforward way divergence may emerge between a physician's assessment and a patient's theory of their illness, leading to resistance, is when the assessment disagrees with a candidate diagnosis the patient suggested or alluded to earlier in the visit (e.g., Heath 1992; Peräkylä 1998, 2002, 2006; Stivers 2002a, 2007). Disagreement may also arise when a patient implicitly or explicitly rules out a diagnosis (Gill, Pomerantz & Denvir 2009), and the physician ultimately settles on that diagnosis later in the visit (Peräkylä 1998, 2002, 2006). In other cases, a physician may not address concerns the patient has conveyed about a more serious condition, e.g., cancer. However, as Thorsen and colleagues (2001) suggest, even when there *is* agreement about a diagnostic label for a patient's condition, there may not be agreement about what it means or how to treat it.

Differences also arise in terms of how participants characterize the nature of a patient's problem. For instance, a patient may characterize a problem as potentially systemic in nature, while a physician focuses on some local symptom only; participants may differ in their emphasis or characterization of a particular symptom; a diagnosis may locate a problem in a different part of the body than where the patient has presented it, and so on. Whereas candidate diagnoses show a fully formed idea of what a problem may or may not be vis-à-vis a clinical diagnosis, discrepancies in a characterization of a problem are less neatly bounded "theories" and may emerge more locally.

Differences between a physician's diagnostic assessment and a patient's theory of their illness may thus be pervasive in primary care.

4.2.2.3 Doctorability of the Problem

Patients also assess their problem in terms of its doctorability. Heritage and Robinson's (2006:58) definition of a doctorable problem is one that is "worthy of medical attention, worthy of evaluation as a potentially significant medical condition, worthy of counseling, and where necessary, medical treatment." Issues surrounding legitimacy and doctorability are pervasive and omnirelevant in primary care settings, and both physicians and patients show attentiveness to these issues throughout the various phases of a medical visit (Heritage 2009). Patients are particularly vulnerable to having the doctorability of their problem challenged, for example when they receive "no problem" diagnoses and/or "no treatment" recommendations (Stivers 2007); when they come in with potentially routine or self-limiting problems like the common cold; or when they present concern about something more serious and risk coming across as unnecessarily worried if the problem turns out to be nothing.

Patient practices for presenting their problem as legitimate or portraying themselves as reasonable patients include diagnostic suggestions and rule-outs, third-party attributions of concern, troubles resistance (Heritage & Robinson 2006a), as well as practices like presenting a serious concern and then suggesting alternate, more mundane causes for the problem (Pomerantz, Gill & Denvir 2007). Patients are also quite attentive to any challenge to the legitimacy of their problem that may arise during the visit. For instance, patients may add unsolicited descriptions of symptoms that support their claim to legitimacy in contexts where the physician's line of inquiry has uncovered a *lack* of symptoms. For instance, during history-taking they have been shown to expand no-problem-indicative answers to physicians' questions (e.g., that they have *not* felt feverish) with the

addition of a separate, problem-indicative bit of information (e.g., that they *do* however feel tired) (Stivers 2007; Heritage 2009). And in physical examinations, patients have been shown to volunteer unsolicited pain information in contexts where a physician has thus-far failed to locate their pain (McArthur 2018). As I will show, observable divergence along the lines of doctorability may emerge for example when patients do work to cast their problem as legitimate and physicians push back against that, or the diagnosis minimizes the patient's problem or treats it as no problem.

But unlike with other aspects of the patient's self-assessment, it is not necessary for a patient to do overt work to cast their problem as legitimate in order for us (and the physician) to see that they have assessed their problem as doctorable. Indeed, this is embedded in their decision to go to the doctor. As Heritage and Robinson (2006:57-58) write, "by the act of making an appointment and walking into the physician's office, patients commit themselves to the belief that they have a legitimate reason for attending," a belief that will itself be judged over the course of the visit. Divergence along these lines may thus emerge any time a physician delivers a no-problem diagnostic assessment, and indeed this is one area that conversation analysts have reported diagnosis resistance (Heath 1992; Peräkylä 1998, 2002, 2006).

4.2.3 The Current Study

In the following analysis I show how divergence observably emerges between patients' and physicians' assessment of the patient's problem along the lines outlined above – departing from a patient's expectations, disagreeing with their theory of the illness, or challenging the doctorability of their problem – and how the resulting gap during counseling occasions diagnosis resistance. I draw on the following types of interactional evidence to support my claims.

First, I draw on distinct features of the patient's description of their problem that go beyond "mere" symptom descriptions and do work to bring their lifeworld concerns closer to the surface of

their talk (Mishler 1984). Such features range from explicit inquiries (“I thought maybe you’d refer me to a dermatologist”) and worries (“I hope it’s not cancer”) to less overt practices like casting the problem as particularly unusual (“it just dumbfounds me...”) or worrisome (“the speed of this scares me”); characterizing a symptom in a way that subtly implies some mechanistic theory of the problem (“it feels like there’s something stuck in there”) or a diagnostic hypothesis (“I’m coughing up colors”); or even simply gesturing toward a particular part of the body, as I will show in Extract 7. Patients also convey their concerns in the ways they push back against the physician’s line of inquiry or characterization of the patient’s problem. None of these practices necessarily reveal a patient’s “true” underlying concerns – indeed, even when patients are most explicit, e.g., requesting a specific test, they may not be revealing their “true” concerns. But these practices are our best way in as analysts and provide sufficient leverage in examining potential bases for later resistance.

In some cases, divergence is observable early in the visit. For instance, a physician may explicitly push back against a patient’s request or diagnostic hypothesis. In other cases, physicians more subtly pursue a line of inquiry that diverges from how the patient has presented their problem. Divergence also becomes observable during physical examination, when physicians engage in online commentary (Heritage & Stivers 1999) that projects a no-problem diagnosis or other divergent diagnostic assessment. Early evidence of divergence (or impending divergence) is not required for divergence to be observable, but when it does occur it is a useful source of insight into the basis for a patient’s later resistance.

The main site where divergence is observable is in the physician’s diagnostic assessment, which is typically conveyed at the shift from information-gathering to counseling activities. In some cases, physicians explicitly orient to their assessment *as* divergent, for example by framing it as in disagreement with a patient’s prior suggestion or accounting for specific differences between the assessment and how the patient presented the problem. But more often than not divergence is only

observable by comparing the physician's assessment of a patient's problem with how the patient has presented that problem. As with early divergence, divergent assessments observably push back against a patient's request or diagnostic hypothesis, or they may more subtly shift away from how the patient cast the nature of their problem.

In each analysis I also examine the patient's diagnosis resistance later during counseling, with an eye toward how it is observably occasioned by or tied to some gap between the patient's concerns and how the physician is addressing them. Resistant actions often observably highlight this gap by revisiting the patient's own earlier comments or concerns from which the physician diverged; challenging, questioning, or more subtly raising some bit of information that calls into question an aspect of the physician's assessment that diverged from the patient's; or in some cases even more explicitly revealing a concern that has been left unaddressed.

In the second part of my analysis, I move to cases with no resistance, drawing on some of these same types of evidence to explore differences in how they unfold that could further explain the interactional processes leading patients to resist diagnostic assessments.

4.3 DATA

As in all chapters in this dissertation, this chapter draws on both the PCT and AMH datasets for observations and illustrative extracts, while all references to frequencies of behaviors are drawn from the AMH dataset. In Chapters 2 and 3 my unit of analysis was individual instances of resistance or their responses. In this chapter, where I am looking at the entire interactional context leading up to diagnosis resistance, my unit of analysis is the entire conversation surrounding a diagnosable problem. In the AMH dataset 70 discussions of diagnosable problems contain at least one instance of resistance and 52 do not.

In my initial analyses I began with cases containing diagnosis resistance, using conversation

analysis to work line-by-line through the problem presentation, information-gathering and subsequent assessment activities preceding resistance. My task was a strictly qualitative one, in that I approached each conversation as a single case study, using the framework, knowledge base and tools of conversation analysis to identify interactional patterns shared in common across these cases. This undertaking was more inductive than other common approaches to doctor-patient communication, where communication practices are often coded according to pre-determined coding schemes neither generated nor validated through close analysis of the data. This tends to result in erasure of the context and meaning of coded conduct, preventing understandings of *why* participants act in certain ways (Heritage & Maynard 2006b), which is central to the questions in this chapter.

Conversation analysis is a more ecologically sound method for identifying how specific behaviors shape later outcomes. This method is often used in a two-step fashion, with close qualitative analyses leading to operationalized coding categories and subsequent quantitative analyses (Stivers 2015). Indeed, this is how I use conversation analysis in the prior two chapters of this dissertation. This chapter differs in that the goal is not quantitative *per se*, but rather to uncover and tell a story, lodged in the particulars of individual cases, about the interactional processes leading patients to resist diagnostic assessments in primary care.

Importantly, though, my analyses were not entirely open-ended, as they were necessarily shaped by my familiarity with *how* a patient ultimately resisted (i.e., the content and design of their resistance) and, in some cases, *what* they resisted (i.e., the local sequential context of their resistance). Although I was not looking for specific types of actions or communication practices, my analytical focus was drawn toward physician and patient behaviors that could observably be part of some through-line resulting in resistance. Conversation analysis is well-suited to this endeavor because it enables identification of the ways participants work toward and thus display particular interactional goals, beyond explicit actions like requests or denials of requests. In the context of medicine, as can

be seen in this dissertation and throughout conversation analytic studies in this area, these tools are critical for seeing what participants are “really” up to, as they so rarely go fully on-record to challenge or disagree with one another.

4.4 ANALYSIS

4.4.1 Observable Divergence Followed by Subsequent Resistance

This first part of my analysis focuses on those cases where patients ultimately resist a physician’s diagnostic assessment during counseling by initiating reversal of the visit’s progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician’s assessment may still be shaped. A common characteristic of these cases, which is not prevalent in cases containing no resistance, is observable divergence between the physician’s and the patient’s assessment of the patient’s problem. I argue that divergence solidifies into a gap during counseling between patient concerns and how the physician is addressing them, which will persist through visit closing absent some move to reopen assessment activities. It is out of this gap that I argue diagnosis resistance emerges.

As previously discussed, the main site where divergence emerges is the diagnostic assessment itself – all cases of observable divergence leading to diagnosis resistance contain an assessment that diverges from how the patient presented their problem. When divergence emerges earlier, i.e., during information-gathering phases, it often comes closely on the heels of whatever work the patient is doing to cast the nature of their problem in a certain way. In some cases, early divergence consists of direct physician pushback against some aspect of the patient’s displayed assessment of their own problem, e.g., a push for some treatment or test, or a stated candidate diagnosis. In other cases, physicians’ line of inquiry more subtly shifts away from how the patient has presented the problem. In either scenario, early divergence signals to the patient that a divergent assessment is

coming, and patients have an opportunity to push back in an attempt to influence the physician's line of inquiry or assessment before that happens. Cases exhibiting early divergence are particularly illustrative because both participants' projects rise more often to the surface of the conversation. Although cases of early divergence and cases of divergence observable only in the assessment are fairly even distributed in the data, most of the cases I show in this section contain both.

I begin this section with a clear case of a through-line from divergence to resistance, such that the patient's early work to cast her problem in a certain way is overt; the divergence of the physician's assessment is immediate, explicit, and pushes back directly against the patient's perspective; the patient's subsequent resistance returns directly to her initial project; and the physician displays an understanding of this in his response. Subsequent cases exhibit variations on this, where the pieces of this interactional trajectory vary in their overtness or work in slightly different ways, but the through-line can nonetheless still be traced.

4.4.1.1 A Particularly Clear Case: Departing from a Patient's Expectations

In the first extract the patient presents with heel pain that was previously diagnosed by a nurse practitioner as plantar fasciitis. Before the doctor enters the room, the patient mentions two candidate diagnoses for her pain to the nurse (a bone spur or a cyst), describes the basis for those candidates ("it feels like there's actually something in there"), and says that she would like an x-ray. Although it is not clear whether the nurse communicates these statements to the physician, and such conversations are not available in other extracts, they are useful in revealing the patient's assessment of her problem before the visit begins.

In line 1 of the extract below, shortly after opening the visit, the physician observes that the patient was "seeing other doctors before" for her foot problem. Cases where a patient brings up a prior acute problem that has already been addressed by another physician are ripe for diagnosis

resistance, as the mere act of re-mentioning the problem indicates some dissatisfaction with how the problem was previously dealt with. In this case, the patient unpacks her issue with the prior visit, saying “I just don’t think we’re gettin’ to the bottom of the problem ‘cause I still can’t walk on my foot” in lines 6-9. On one hand the complaint “I still can’t walk on my foot” indicates effects of the problem on the patient’s functionality and may indicate a desire for treatment. However, it is embedded as an account for why the patient doesn’t “think we’re getting to the bottom of the problem,” which more directly rejects whatever diagnosis she was given in a prior visit and makes relevant further diagnostic inquiry.

The physician, however, takes up the treatment implication of the patient’s utterance with “have you ever gotten steroid injections in your foot for this” in lines 12-13. This line of inquiry disattends the patient’s rejection of her prior diagnosis and foreshadows an assessment that further diagnostic inquiry is not necessary.

(1a) PCT 21-06 Problem presentation into history-taking

1 DOC: You were seeing other doctors [before.
2 PAT: [Right.
3 DOC: .h[hh
4 PAT: [Well I saw ((name)) an' (0.5)
5 DOC: °Ka[:y, °
6 PAT: -> [I just don't think we're gettin' to the bottom
7 -> of the problem 'cause [I still can't walk
8 DOC: [.hhh
9 PAT: -> on my foot.
10 DOC: Oka:y.
11 (0.2)
12 DOC: Have you ever:=h gotten: (0.5) steroid injections
13 in your foot. fo[r this.
14 PAT: [No.
15 (1.2)
16 DOC: A:[nd (.) it's-
17 PAT: -> [<But we don't even know what it is yet.
18 (0.2)
19 PAT: -> No x-r[ays or nothin'.
20 DOC: [(We'r-)
21 (0.8)
22 DOC: X-rays probably aren't going to show anything.=
23 Let's: (.) .hh[h
24 PAT: [It's ver-
25 DOC: 't's see where the pain is.

The patient disconfirms with “no” in line 14, giving a sequential “go-ahead” for recommendation of this treatment as a potential resolution to her problem (Schegloff 2007). After a 1.2-second silence in line 15 the physician is about to move on with “and it’s...” in line 16, but the patient quickly initiates an additional turn, returning to this issue of diagnosis with “but we don’t even know what it is yet” in line 17. The turn-initial “but” frames this as an expansion of her prior response, and casts her rejection of the prior diagnosis as grounds for blocking movement to treatment. This treats the physician’s line of inquiry focusing on treatment as divergent from her own assessment of the problem as one of diagnosis first.

The patient further expands this response with an account for why she thinks “we don’t even know what it is yet,” which is that she’s gotten “no x-rays or nothin” in line 19. This upgrades the patient’s push for a diagnosis into an explicit project for a diagnostic test. The physician responds with “x-rays probably aren’t going to show anything” in line 22. Whereas the physician’s prior turn began to foreshadow a divergent assessment from the patient’s via a subtle shift in his line of inquiry away from the patient’s focus on diagnosis, this turn more explicitly pushes back against the patient’s bid for an x-ray, along with whatever diagnostic hypothesis may be underlying it (i.e., that it’s something an x-ray might “show”). The physician then moves into physical examination with “let’s... see where the pain is” in lines 23-25 and a move toward the patient’s foot, shutting down this sequence while also submitting somewhat to the patient’s bid for diagnostic investigation.

At the end of the physical examination the physician pushes his chair away from the patient and delivers a diagnostic assessment with “well I mean it’s been diagnosed before as plantar fasciitis” in lines 1-2 below. This diagnosis projects no further investigation, clearly diverging from the patient’s own assessment of her problem as meriting an x-ray. Moreover, the physician designs the assessment *as* divergent; by framing it as something that’s “been diagnosed before as...” he casts this not as his own new diagnosis, but as an alignment with the prior clinician. He thus overtly

displays his assessment that no further inquiry was merited from the start, challenging the legitimacy of the patient's decision to come back.

(1b) PCT 21-06 Assessment into treatment

1 DOC: Well- I mean<it's been diagnosed befor:e as
2 plantar (0.2) fasciitis.
3 (0.8)
4 DOC: You know what that is,
5 (0.5)
6 DOC: Anyone explain to you [what it is?
7 PAT: [Yeah the muscle thing?
8 (0.8)
9 DOC: .hk Well, t's=it's sort of like (.) the muscle,
10 it's actually a fibrous band that attaches to
11 the heel bone, .hh comes forward in the foot and
12 spreads out, .hhh as we get older, (0.5) it tends
13 to stiffen:, and shorten.
14 (0.2)
15 DOC: and then: [activity-
16 PAT: -> [All of a sudden?
17 (0.8)
18 DOC: We:ll it can: hit all of a sudden=I mean the
19 stiffening and shortening is going on gradually
20 but the symptoms can hit all of a sudden. .h [u:m
21 PAT: -> [I
22 -> actually feels like there's something in my foot
23 -> though when I stand on it.
24 (0.8)
25 PAT: -> Is that normal,
26 (0.5)
27 DOC: Yeah.
28 (0.2)
29 DOC: Well (0.8) it's tight.
30 (0.2)
31 DOC: (you know/ in uh) in there.
32 (0.2)
33 DOC: U:m (1.2) .pt and it gets infla:med and it gets
34 painful. .hh Now what have you been doing for it.

After no patient response, the physician asks “you know what that is... anyone explain to you what that is” in lines 4-6, displaying an understanding of her silence as an indication of non-understanding rather than non-acceptance. The patient both confirms and demonstrates understanding with “yeah the muscle thing?” in line 7, which the physician takes up and expands by explaining that it’s “sort of like the muscle” but “actually a fibrous band” that stiffens and shortens with age (lines 9-13). As he’s about to continue this in line 15 (“and with activity...”) the patient

comes in in overlap to resist with “all of a sudden?” in line 16. On its face this turn requests confirmation of a candidate understanding of what the physician has been saying, but it also points out that the onset of her symptoms was “all of a sudden,” and questions the fit of her experience with this diagnosis (“questioning the symptoms” described in Chapter 2).

The physician confirms and explains how the symptoms of plantar fasciitis *can* hit all of a sudden in lines 18-19. In line 20, the patient again questions the diagnosis, this time by describing a symptom (“I actually feels like there’s something in my foot though when I stand on it”), which she frames as a contrast to the physician’s explanation with “actually” and “though,” and then turns into another instance of questioning the symptoms with “is that normal,” in line 25. The physician again confirms the fittedness of this symptom to the diagnosis with “yeah” and an explanation that “it’s tight... and it gets inflamed and it gets painful” in lines 29-34 before moving on to treatment with “now what have you been doing for it.”

After discussing anti-inflammatories, orthotics and stretching the foot, the physician begins recommending icing her heel by rolling a frozen water bottle under the foot. When the physician is obviously in the middle of this recommendation the patient comes in in line 3 below to ask, “are we sure that’s what I have?”

(1c) PCT 21-06 Counseling

```
1 DOC: Well (.) here's what could work well. .pt .hh
2 Get a bottle of water. (0.5)
3 PAT: -> Are we sure that's what I ha:ve?
4 (0.5)
5 DOC: Yeah.
6 (2.2) ((DOC looking at chart))
7 DOC: ^If you want an xray we can do an xray,=
8 PAT: -> =Yeah [I'd (rather) do that, I mean: I don't wanna
9 DOC: [(to make sure,)]
10 PAT: -> take ((name))'s word for it,=not that I don't
11 -> trust her but (0.5)
```

After minimally confirming with “yeah” in line 5, the physician gives in to the patient with “if you want an x-ray we can do an x-ray” in line 7. This offer is a rare example of a physician

changing course in the face of diagnosis resistance and framing that change of course as occasioned by the resistance itself (n=0 in the AMH dataset). It also displays an understanding of the patient's ongoing resistance as continuing in pursuit of an x-ray, which the patient aligns with in line 8: "yeah I'd rather do that."

In this case the through-line from divergence to resistance is clear and straightforward. The patient does early work to overtly display a desire for further diagnostic investigation, particularly an x-ray. The physician initiates a line of inquiry focused instead on treatment, and then pushes back explicitly against the x-ray and whatever diagnostic hypothesis may be underlying it, constituting early divergence. (Indeed, all cases where a patient so explicitly pushes for a particular outcome – here a diagnostic test but in other cases referrals or, as in the next extract, treatment – divergence emerges early.) The physician then delivered a diagnostic assessment that observably diverged from the patient's project by aligning with the diagnosis established by the previous clinician and thus casting further investigation as unnecessary. During counseling, the patient's series of diagnosis resistance observably returned to her original desire for renewed investigation, and implicitly renewed her bid for an x-ray. Finally, the physician oriented to the patient's resistance as indeed a return to her earlier project, and as arising out of the gap resulting from the divergence of his assessment with hers.

4.4.1.2 Patient Expectations Bound up with Issues of Legitimacy

In the next extract the patient similarly displays expectations for a particular outcome – antibiotics – but rather than naming this outright she bids for it through symptom descriptions implying a treatment-implicative candidate diagnosis, and by more generally working to cast her problem as legitimately serious. The physician's line of inquiry diverges from the patient's assessment of her problem as antibiotics-relevant more subtly than in the prior case, but the patient

nonetheless orients to it *as* divergent in the further work she does to cast her problem in this way.

The physician initiates this visit with a problem solicitation proffering a candidate (“What’s going on is it your asthma or something else going on” in lines 1-2; see Heritage & Robinson 2006b). The patient indeed has a documented history of asthma, which both participants draw on over the course of the visit. But the patient disconfirms that this is the *reason* for her visit with “Ye- <no” in line 3, followed by a presentation of acute upper respiratory symptoms. The patient initially minimizes the onset of her symptoms with “just feeling a little run down and tired and a little bit of a cough” in lines 3-6, but then contrasts this with “overnight it went full blown” in line 7. This is the beginning of the ongoing work she will do to portray her symptoms, which only just began, as fast-moving, worrisome, and clearly indicative of impending serious illness. She adds that she is “coughing up colors” in line 7, which is a classic way patients imply a diagnosis of a bacterial infection and display an expectation for antibiotics (Stivers 2002a, 2007; Filipetto et al. 2008).

The physician takes up “coughing up colors” with “oh” in line 8, displaying a change of state from his initial expectation that the problem is asthma, and orienting to this symptom as not related to asthma (Heritage 1984b). Before he can say anything else, the patient adds that she’s experiencing “nausea, headache, joint pain, like my back is killing me... my shoulder’s beginning to bother me...” in lines 9 through 12. These additional symptoms, presented as a list, work to support the patient’s claim that her illness is suddenly “full blown,” but they also interactionally bury the implied candidate diagnosis of an upper respiratory infection. In response, the physician takes up and topicalizes the last symptoms in the list – back and shoulder pain – rather than the patient’s upper respiratory symptoms, with a request for confirmation that “It’s causing a lot of muscle aching and stuff” in line 14.

(2a) AMH 02-13 Problem presentation into history-taking

1 DOC: What's goin' on=is it your asthma or something
2 [else (goin' on).

3 PAT: [Yea-<no:: I=it started yesterda:y, (0.2) u:m just-
4 not- fe- just feeling run dow:n an' (0.2) [tir:ed an'
5 DOC: [Yeah.
6 PAT: -> a little bit of a cough and then overnight it went
7 -> full blown (.) u:m (0.2) coughing up color:s an:=
8 DOC: =°O:[h°
9 PAT: [.h nausea:'n (0.2) headache (.) joint pain:
10 (.) <like my ba:ck is killing me,
11 DOC: O:h [okay.
12 PAT: [My shoulder's beginning to bother me so whatever
13 I have (0.5) has decided to: (0.5)
14 DOC: It's cau[sing a lot of [muscle achin[:g (and [stuff,)
15 PAT: [Full- [full on- [Yea:h. [The a-
16 w- and als- but it's mor:e- I can deal with muscle
17 -> aches. all day long.=that's: no big deal. it's (0.8)
18 -> the fact that I'm: (0.2) oxxygen depri:ved an'
19 -> coughing up colors which scares the crap out of
20 -> mē which means that things are about to get very
21 -> b[ad.
22 DOC: [.pt I: see.
23 PAT: So.=
24 DOC: =Whe- when did you get sick,
25 (0.2)
26 PAT: Uh it started yesterday?
27 (.)
28 DOC: [Oh just yesterday.
29 PAT: -> [So the sp- the speed of this is scaring me,
30 DOC: °(Okay)° Did y- did you have- did you get your flu vaccine,

The patient, who is in the midst of restating that her symptoms are “full on,” confirms this with “yeah” in line 15. But she then explicitly casts her muscle aches as unproblematic (“I can deal with muscle aches all day long, that’s no big deal” in lines 16-17) and redirects the physician to her main concern: “It’s the fact that I’m oxygen deprived and coughing up colors which scares the crap out of me which means that things are about to get very bad” in lines 17-21. This continues the patient’s project to cast her problem as clearly indicative of impending serious illness, which she supports by recycling her symptom description that she’s “coughing up colors,” and drawing on her history with asthma to upgrade her concern by describing herself as “oxygen deprived.” Moreover, by casting aside muscle aches as relevant to her concern and then foregrounding the antibiotics-implicative “coughing up colors,” the patient orients to the physician’s line of inquiry as divergent from her primary concerns and attempts to redirect him.

The physician takes this up with “I see” in line 22, then asks “when did you get sick” in line

24. This puts the patient in a position of having to reiterate that her illness only just began, which the physician underscores with “oh just yesterday” in line 28. This pushes back against the patient’s work to cast her problem as serious and indicative of antibiotics, and is further evidence of early divergence. The patient orients to this as divergent and problematic by recasting the recent onset of her symptoms as in fact *cause* for concern with “so the speed of this is scaring me” in line 29.

After some intervening talk about the flu vaccine and a brief physical examination, the physician begins to ask another question (which will ultimately be about treatment) but interrupts himself to initiate a shift into assessment and counseling with “it sounds like you’re coming down with a virus” in lines 1-2 of the next extract. Despite his concession that “it might be the flu” in line 3, this assessment is not antibiotics-implicative, and observably departs from the patient’s displayed expectations. The physician then asks whether the patient has had any fever yet, which the patient disconfirms with obvious reluctance in lines 7 (“U::m”), 10 (“N:-”), and 13-14 (N:: not really,”).

(2b) AMH 02-13 Assessment into Counseling

1 DOC: So: (1.0) lemme ask you something.=I mean it sounds
2 like you're coming down with a virus='n (0.2) y'know it
3 might be: (0.5) flu (0.2) it's=it's kinda early to
4 know right, .hhh um (0.2) <do you think the fever's
5 been (0.2) much=hh yet,
6 (1.0)
7 PAT: .t U[::m,
8 DOC: [I know you've had achiness and stuff,
9 (0.8)
10 PAT: N[:-
11 DOC: [Felt feverish °at all,°
12 (1.2)
13 PAT: N:: ((turns both palms up, then drops hands to lap))
14 Not really,
15 DOC: °Mkay° ((nodding)) .hh (1.0) What do you: think
16 (0.5) when you feel something like this coming o:n
17 (0.8) your long history of (.) \$asthma\$ (0.5) what
18 usually works best.
19 PAT: -> #Antibiotics,# ()- cause otherwis:e (0.2) this
20 just keeps building and building and building to
21 the point where I [can't (.) get out of be:d.
22 DOC: [Yeah.
23 DOC: **And [in terms of your breathing and such. um (1.0)**
24 PAT: [Can't breathe.
25 DOC: **Do you: (0.5) It sounds, (.) right now, when I**
26 **listen to you. (0.8) you have um (0.8) it sounds**

3 DOC: [Okay.
4 PAT: -> Might be getting a little bit of a:: ear infection
5 -> in my left ear:,
6 (1.2) ((DOC maintaining gaze))
7 DOC: It's just painful:, or pressur:e,
8 PAT: It's definitely a bit pressure in both ea[r:s.=
9 DOC: [Okay.
10 PAT: =The left one is just (0.2) starting to get
11 pain:ful:
12 DOC: Okay.
13 PAT: this: morning.
14 DOC: Okay:.

The physician displays an orientation to the patient's shift from a focus on his cough to a mention of an ear infection as somewhat unexpected with a 1.2-second silence in line 6. During this silence he maintains gaze with the patient, pursuing expansion of this candidate diagnosis (Stivers & Rossano 2010; Rossano 2012). When the patient adds nothing, the physician pursues evidence to support the diagnosis by proffering two candidates, ear pain or pressure, in line 7, which the patient confirms in lines 8 through 11. So far there is no observable divergence between the patient's candidate diagnosis and the physician's subsequent investigation.

This candidate diagnosis may be hearably mentioned as part of a broader bid for antibiotics, given its sequential context. Nonetheless, it *was* named, and reveals one aspect of the patient's theory about what is wrong with him. Following further history-taking and some physical examination of the patient's lungs the physician begins to examine the patient's ears in the following extract. After looking in the patient's left ear – the one he specified may be getting infected – the physician does some online commentary foreshadowing a no-problem diagnosis (Heritage & Stivers 1999) with “this ear looks good” and “no infection there” in lines 2-3. Here the physician's investigation begins to observably diverge from the patient's diagnostic hypothesis. The patient assesses this with “that's good” twice, in lines 4 and 5, a not-uncommon response to rule-outs of serious illness even in such contexts of disagreement. However, as the physician looks in his other ear, the patient adds that he feels like “there's been so much fluid up in there though” in lines 7-8, challenging the physician's observations, renewing his concern that he has an ear infection, and orienting to the physician's

comments as indeed divergent.

(3b) AMH 03-04 Physical examination

1 (5.0) ((DOC looking in left ear))
2 DOC: ((moving to right ear)) °This ear looks
3 goo[::d? No infection ther::e,°=
4 PAT: [°That's good.°
5 PAT: =W'll tha:t's good.
6 (1.5) ((DOC looking in right ear))
7 PAT: -> I feel like there's been: so much fluid up
8 -> in there though.=
9 DOC: =Yea::h. Nothing that I see: her:e.
10 (0.2) ((DOC still looking in right ear))
11 DOC: So it looks good.=It's not red or
12 any[thing:.=I think it's coming more from the
13 PAT: [Oh that's good.
14 DOC: sinuse[s (and the cough.)
15 PAT: [Yeah=yeah that could definitely [be it.
16 DOC: [that
17 pressure ge[ts (transferred there.)
18 PAT: -> [I had chr::onic ear infections when
19 -> I [was a ki:d so[: [(kinda like-)
20 DOC: [Yeah. [Yea:h.[<See some scarr:ing there
21 that's about [it. But yea:h other than that .hh
22 PAT: [Yeah.
23 DOC: it looks pretty goo:d.
24 PAT: Yeah. That's good.

The physician's investigation and impending assessment continue to diverge from the patient's diagnostic hypothesis when he reiterates that there's "nothing that I see here" in line 9, adding further evidential support against an ear infection ("it looks good, it's not red or anything") in lines 11-12, and providing an alternate explanation for the patient's ear pain ("I think it's coming more from the sinuses and the cough, that pressure gets transferred there") in lines 12-17. Indeed, the physician will ultimately diagnose the patient with a sinus infection, which is a "problem" diagnosis indicating antibiotics. Thus, what the physician is setting up for and orienting to here is disagreement with the patient's candidate diagnosis.

The patient again explicitly agrees with "yeah that could definitely be it" in line 15, but adds a further account for, and thus a return to, his concern about an ear infection with "I had chronic

ear infections when I was a kid so...” in lines 18-19. The physician takes this up and clinically validates it with “yeah see some scarring there” but then works again to rule out an ear infection with “that’s about it, but yeah other than that it looks pretty good” in lines 21-23. In this case the physician’s online commentary pushes back against an ear infection and thus constitutes observable divergence between his investigation and impending assessment and the patient’s diagnostic hypothesis.

After the close of the physical examination the physician delivers a diagnosis of “a little sinus infection” in line 1 below, which is observably divergent because it disagrees with the patient’s candidate diagnosis. In the course of explaining this diagnosis, the physician suggests that the patient’s sinus infection is part of his body’s “first line of defense.” The patient pushes back against this with diagnosis resistance, volunteering that he’s “been stuffed up for a long time” in lines 5-6.

(3c) AMH 03-04 Assessment into Counseling

```

      ((DOC facing PAT to deliver Dx))
1  DOC:  .h So >I think< you got a little sinus infection,=
2        You got a lot of fullness in the no:se. .hh So
3        that's your first line of defense. So as that
4        [stuff comes i:n, (0.2) your body sort of rea:[cts,
5  PAT:  -> [Yeah.                                     [I've
6        -> been stuffed up (0.2) [f- for a l:ong time.
7  DOC:                                     [Yeah.
8  DOC:  Yea:h and then you can get that post-nasal drip. So
9        that's [(in the chest and the cough there.) .hh U:m
10 PAT:  [(causing cough,)
11 DOC:  hh .t a:nd it's been how many:- how many: [weeks
12 PAT:                                     [The n-
13 DOC:  [that you said the stuffiness [and the congestion,
14 PAT:  [the: s-                               [the stuffiness and
15        congestion has been since a week ago Monday at [least.
16 DOC:                                     [Okay.

```

This resistance is tied to the patient’s diagnostic hypothesis of an ear infection, though rather subtly. By suggesting that he has in fact had sinus symptoms “for a long time” the patient suggests that, if sinus symptoms are the “first line of defense,” then he is past this stage. This does not directly assert that the patient’s problem may instead be an ear infection, but it re-introduces the possibility of it. Later in the visit, the patient explicitly re-invokes his candidate diagnosis by

mentioning that his son just had an ear infection (not shown).

As in the prior two extracts, the physician's assessment is observably divergent from the way the patient presented his problem, here because it disagrees with the patient's diagnostic hypothesis. In other cases of disagreement with a candidate diagnosis or a patient's theory of the illness, this is the only place divergence is observable. In this case divergence is also observable earlier in the visit, when the physician engages in online commentary paving the way for a diagnostic assessment other than what the patient has hypothesized. The resulting gap out of which the patient's resistance emerges is again straightforwardly observable – the patient thinks he has an ear infection, and the physician does not.

4.4.1.4 Challenging the Doctorability of a Patient's Problem

In the next extract the lines along which the physician's assessment diverges is the doctorability of the patient's problem. As discussed above, unlike with other aspects of patients' assessments of their problems, it is not necessary for a patient to do overt work to cast their problem as legitimate in order to see that they have assessed their problem as doctorable, as this is embedded in their decision to go to the doctor. Diagnostic assessments that prototypically diverge from this assessment include routine, self-limiting, and/or no-treatment diagnoses such as viruses and sprains; assessments that there more vaguely *is* no problem, or no evidence of a problem; and reassurances/ rule-outs of specific conditions with no alternative diagnoses suggested, leaving symptoms unexplained and treated as no problem. When patients receive a no-problem diagnostic assessment, the divergence between their orientation toward the problem as doctorable and the physician's orientation toward it as not may lead to a gap during counseling where the patient can see that their concerns will not be addressed, leading to resistance.

In this extract the physician explicitly casts the patient's problem as not a medical problem.

This patient has multiple potentially serious concerns, including chronic pain and concerns about exposure to heavy metals; early in the visit, after listing but not yet describing two of these concerns, she adds in line 1 that she is also concerned about the “double lids” on her eyes. She makes a bid for diagnostic commentary by asking “is that from crying too much or is that just age” in lines 1-3. She then works to rule out the effects of age by pointing out that she’s “perpendicular most of the time” (likely meaning “horizontal”) in line 5, and so “you could say it’s gravity but I’m really like in bed most of the time with pain” (referring to her hip and leg pain) in lines 9-12. Suggestions like this work not only to suggest (or here, rule out) a certain line of inquiry (Gill, Pomerantz & Denvir 2009), but may also be used, as Heritage and Robinson (2006) put it, as a “shortcut to legitimacy.”

(4) AMH01-01 Problem presentation through diagnostic assessment

```

1 PAT: -> And also:, um: (0.8) I have double lids no:w.=Is
2         -> that (0.2) from: (.) crying too much, or: is that
3         -> just age.
4         (0.2)
5 PAT: -> 'Cause I'm: perpendicular most of the t(h)ime.
6 DOC:   hm hm
7 PAT:   .hhhh
8 DOC:   [U::m,
9 PAT: -> [I mean this- you could say it's gra:vity but I'm m-
10        -> reall:y like (.) in bed most of the ti[:me. With pain:.
11 DOC:                                     [Yea:h.
12 DOC:   °Mm hm:, °
13        (0.2)
14 DOC:   Yea:h.
15        (0.8)
16 DOC:   U::m °I can-° Yeah I see- U:h I think I see what
17        you're saying. Yeah. .h I don't think it's:
18        anything medical:.=It could probl- it's probably
19        that [but-
20 PAT: -> [It's becoming medical because my:- (0.2) my:-
21        (0.5) second li:d is sitting on my eyes and it's
22        (.) it- (.) I have migraines all the time.=So it's
23        really hard to .hh (0.5) you know (1.0) I have one
24        right now. Does tha:t light have to be on:?
```

The physician does not engage in history-taking or physical examination, which is itself a challenge to the doctorability of the problem, as it orients to the problem as not “worthy of evaluation as a potentially significant medical condition” (Heritage & Robinson 2006a). He does say “I think I see what you’re saying” in lines 16-17, potentially attending to the problem of commenting

on the nature of a patient's problem without first establishing even nominal common ground about its presentation. However, he does this without any overt display of actually examining the patient's eyes. He then delivers a diagnostic assessment that "I don't think it's anything medical" in lines 17-18. He adds "it's probably that" in lines 18-19, but what "that" is referring to is unclear. This diagnostic assessment is therefore explicitly and fairly exclusively concerned with ruling out the legitimacy of the problem *as* a medical problem and constitutes an obvious challenge to the doctorability of the patient's problem. In this case the patient immediately and directly challenges this assessment, saying "it's becoming medical" and linking the problem to her chronic migraines in lines 20-24.

4.4.1.5 Obvious Divergence but Unclear Underlying Concerns

The next extract differs from those shown so far in that we can see that there *is* a through-line from divergence to resistance, but it is less clear what the patient's underlying concern is. What's important is that, as in prior cases, there *is* divergence pointing to a resulting gap between the patient's concerns and how the physician is addressing them, and the patient's subsequent resistant observably arises out of that.

In this visit the patient has presented with pain in her rib cage area – what she describes as "point tenderness" – which was preceded by a persistent cough that she supposes may have caused her to "tweak something" (not shown). This suggests a muscular injury, but she goes on to add that despite taking anti-inflammatories and using a warm compress – both of which may ameliorate muscle pain – her pain has persisted. This works to potentially rule out a muscle injury, or at least a routine injury that one can treat oneself. She then adds that she "doesn't know why it hurts so much" (not shown), which orients to the problem as non-routine and conveys some expectation of diagnostic investigation of it as such.

During history-taking the physician asks if the patient has experienced “any wheezing or whistling noises” in line 1, which indeed pursues a line of inquiry treating the problem as potentially more serious than a routine muscle injury (e.g., a punctured lung from a rib fracture). The patient disconfirms with “no wheezing” in line 2, but works to maintain the possibility of a severe problem with “not that I’ve noticed” in lines 2-4; she then re-emphasizes her suffering through a demonstration of her symptoms in lines 5-12 (“but like ((cough)) you know like when that happens? ... I’m just like oh my god... it hurts”; see Heath 2002). The physician takes this up with a series of collaborative completions in lines 8 through 10, and then makes a bid to move to physical examination with “let’s take a look” in line 11. This move precipitates an additional turn from the patient, “so I didn’t know if I needed a chest x-ray” in lines 15-16, which makes far more explicit an expectation for diagnostic investigation.

(5a) AMH 03-11 History-taking

1 DOC: Any wheezing:=er:: [whistling noises,=[Okay.
2 PAT: [No wheezing, [Not that I:
3 (0.2)
4 DOC: Okay.
5 PAT: that I’ve noticed.=[but like [(cough)) you
6 DOC: [Okay. [Alright.
7 PAT: know like when that [happens? It (k(h)i-
8 DOC: [When that happens.=Yea:h.
9 PAT: I’m (just [like) #o::h my: go:d#
10 DOC: [You can feel it.=^Aw:::: Alright
11 [let’s take a (look).
12 PAT: [It ^hur::[ts.
13 DOC: [^Yea::h.
14 DOC: [Yea-
15 PAT: -> [So- I didn't know if I needed- (0.5) a \$chest
16 -> xr(h) [ay=I don't know I-
17 DOC: [Yea:h we'll take a list[en:. Because:=hh
18 PAT: [I just (don't know
19 PAT: what- [)
20 DOC: [.hh Yea:h sometimes y- you can strain a
21 muscul:e in your chest. from coughing.
22 PAT: Yeah.=
23 DOC: =U::m and that's what it sounds like.=If you
24 had a cough before.=that'[s been lingering
25 PAT: [Yeah.
26 DOC: that lo:[ng,
27 PAT: [Yeah.
28 DOC: That- that may be the cause of it.

29 PAT: Ye[ah.
 30 DOC: [But we'll take a liste[n:.
 31 PAT: [Yeah.
 32 DOC: U:h [no fevers or chill[:s anything [like
 33 PAT: [(That's fine.) [No:. [No.
 34 DOC: [that,=Okay.
 35 PAT: [Well not now.
 36 DOC: Not [no:w. [That's all gone.=Oka[y.
 37 PAT: -> [That's all [resolved. [But I'm
 38 -> just thinking [why is it taking so long for it
 39 DOC: [^Yea:h
 40 PAT: -> for it to go away.

Notably, up until this point there has been no divergence between how the patient is presenting her problem and the physician's line of inquiry. It is indeed this explicit mention of an x-ray – which as I mentioned always results in early divergence – that occasions pushback from the physician. The physician responds with “yeah we'll take a listen” in line 17. Although the “yeah” takes up the patient's inquiry and projects a potentially agreeing response, “we'll take a listen” defers judgment on the appropriateness of an x-ray until after the upcoming exam, declining to respond in the moment and providing for the possibility that the exam may reveal no need for such a test. The physician begins to expand this response with “because” in line 17 but then restarts with “yeah” in line 20 before delivering a preliminary diagnosis with “sometimes you can strain a muscle in your chest from coughing.” The initial “because” casts this as an account for the deferring response, but the restart to “yeah” also casts it as responsive to the patient's “I don't know what-” in lines 18-19, orienting to her elided question as bidding for this kind of diagnostic commentary. Nonetheless, a preliminary diagnosis of a muscle strain supports a no-x-ray outcome, and accounts for the physician's original deferring response.

The physician then explicates some of the evidence in support of this preliminary diagnosis (“that's what it sounds like, if you had a cough before that's been lingering that long, that may be the cause of it” in lines 23-28), orienting to the departure of this response from the patient's expectations and pursuing acceptance (Peräkylä 1998). He then repeats “but we'll take a listen” in

line 30. This reasserts the physician's initial deferring response; however, coming on the heels of a preliminary diagnosis and designed with a contrast-implicative turn-initial "but," it also comes across as tempering the finality of the assessment and leaving room for the possibility that the examination could reveal something else.

On one hand the physician's response to the patient's x-ray inquiry is designed *not* to come across as overtly shutting down the patient's expectations, through yeah-prefacing and an orientation to the possibility that the preliminary diagnosis could be wrong. Nonetheless, deferring responses like this one are commonly used to push back against patients' early requests for particular outcomes like tests, treatment or referrals, and clearly project a divergent assessment of the patient's problem.

Following the physical examination, the physician transitions into counseling with a diagnostic assessment in lines 1-2 below: "So you have a... more than likely a muscle strain along your ribs there." Muscle strain diagnoses are the most minimal, self-limiting type of injury, which require neither further testing nor clinical intervention, and may be used as a diagnostic catch-all for no-problem pain complaints (Cohen 1943; Howie 1972). This assessment observably diverges from the patient's suggestion that she may need an x-ray, and with her work to cast her pain as more serious than you'd expect from a routine muscle injury. The physician orients to this divergence by accounting for it (Peräkylä 1998), tying the diagnosis to her reported symptom of "point tenderness" (which itself may have been intended to be x-ray-implicative) in lines 4-6, and citing negative evidence against the more serious possibility of a punctured lung with "the lungs sound great... you're moving air really well" in lines 8-9.

(5b) AMH 03-11 Assessment into Counseling

1 DOC: So yeah.=So you have a:: (0.2) more than likely
2 a- u:h a muscle strain along your ribs there.
3 PAT: (You thi[nk.]
4 DOC: [So that's where you get that [point
5 PAT: [(Okay.)
6 DOC: tenderne:[ss and when you take the big breath
7 PAT: [Yeah.

8 DOC: but the lungs sound great. You're moving air
 9 [really well.
 10 PAT: [Mm hm.
 11 PAT: Mm hm.
 12 (0.2)
 13 DOC: U::m (0.8) you were taking ibuprofen not really:
 14 (.) h[elping.
 15 PAT: [Six hundred TID.
 16 (0.5)
 17 DOC: So have you tried Ale:ve?
 18 (0.2)
 19 PAT: I haven't tried A[leve.
 20 DOC: [Ookay.
 21 (0.8)
 22 PAT: You think I should try [Aleve,
 23 DOC: [Yea:h, and then you can
 24 DOC: also try icing and al- you can alternate ice
 25 a[nd heat.
 26 PAT: [Yeah I've been trying that.

The physician then moves into treatment talk in line 13, asking if the patient has taken ibuprofen. The patient takes up this recommendation in line 22 but pushes back against the subsequent recommendation for ice and heat with “yeah I’ve been trying all that” in lines 26 through 30. She adds that she’s an NP (nurse practitioner) in line 30, lending credibility to her ability to identify “all the stuff,” and broadening the range of treatments she can be heard to have tried. That she has tried everything suggests that treatment is not what the patient is here for. The physician interprets her utterance in this way when, rather than continuing to recommend treatment, he responds “So you don’t need me” in line 32, sitting down.

26 PAT: [Yeah I've been trying that.=like [the icy
 27 DOC: [Oh you did
 28 PAT: [ho:t,=I've been using the hot compre[ss,='n .hh
 29 DOC: [that.=Ookay. [^O:h ma:n.
 30 PAT: all the stuff. .h [>I mean< (.) I'm an NP: [at
 31 DOC: [Yea:h [O:hh
 32 [heh heh ^\$So yo[u don't need me:=he[e: eh heh heh.
 33 PAT: -> [((place name)) [So:- [^No: but I
 34 -> just (.) I'm- I'[m >thinking to myself< going
 35 DOC: [Yea:h.
 36 PAT: -> (0.8) okay ho[:w lo:ng does this take to go away.
 37 DOC: [Yea:h.
 38 DOC: Yea:h so- the problem with- with these
 39 muscle[s is that you're always using 'em.
 40 PAT: [Yeah.
 ((25 lines of omitted explanation))
 41 DOC: A:nd that (.) injures 'em again:so even
 42 though they're trying to heal up you cough and

resistance trajectory is observable, and the patient's resistance observably arises out of the resulting gap between whatever her underlying concerns *are* and the physician's assessment.

4.4.1.6 Subtle Divergence but Resistance is Illuminating

The next extract illustrates a case where the patient much more subtly displays his assessment of the nature of his problem – that it's potentially systemic in nature – and the physician's subsequent line of inquiry and assessment more subtly diverges from that assessment, as he attends only to the symptom the patient is immediately presenting with. Nonetheless, divergence is clear, and the patient's resistance is clearly occasioned by it. This case is noteworthy in that the patient's resistance in fact reveals *more* explicitly what his unaddressed concerns are, retroactively shedding light on what he was subtly working to convey about his problem in the first place.

The patient presents with a wound on his leg, pulling a bandage off the wound and showing it to the doctor in lines 1-5. After presenting the wound to the physician, the patient says that it “started by just rubbing” himself in 11, which he emphasizes by repeating “just rubbing” in line 14.

(6a) PCT 11-05 Problem presentation

1 PAT: My- u- my pro:blem doctor
2 (0.2)
3 DOC: Yes.
4 PAT: It's that- that- u:h (0.2) (there's) this littl:e (.)
5 thing. ((pulling bandage off wound))
6 (.)
7 DOC: [(I can't)-
8 PAT: [I can't see it my: w- se:lf,
9 (.)
10 DOC: Uh h[uh?
11 PAT: -> [It started by just rubbing mysel:f,
[((bandage off, DOC looks))
12 (1.0)
13 DOC: (For)- ((pulls out table extension for PAT's legs))
14 PAT: -> Just rubbing:.

The patient then adds what looks like an increment pursuit of response with “like... and it happened” in line 16. However, the slight pitch rise at the end of this is on the whole word

“happened” rather than rising toward just the last syllable, making the intonation hearable as indicating impending continuation rather than turn ending. The patient continues in line 20, replacing the past tense “happened” with the present tense “happens,” initiating a shift from talk about this leg wound in particular to wounds like this more generally. He says “it happens every time I rub myself” in line 20 and then rushes through to add “you can see all these spots, and I get a bruise” in lines 21-22. With this he is pointing to his forearm and the back of his hand, not his leg. By shifting to describe a recurring problem and gesturing to areas of his body beyond his leg, the patient shifts from an orientation to his problem as the leg wound to something potentially more systemic in nature.

14 PAT: -> Just rubbing:.
 15 (0.2)
 16 PAT: like (.) e- and it happened,
 17 (0.2)
 18 DOC: Mm hm,
 19 (0.2)
 20 PAT: -> It happens every time I rub myself,=you can see all
 21 -> those spots, ((pointing at arms/hands)) .hhh and
 22 -> I- and I get a bru:ise.
 23 **DOC: How many day you have this, ((points to leg))**
 24 (0.2)
 25 PAT: -> Oh that's going on already (about) (0.5) 'most two
 26 weeks:. ((pointing at leg))
 27 DOC: Two wee[ks?
 28 PAT: -> [And it started like ju:st a little scratch
 29 -> u- u- barely [the skin:. ((pointing to hand))
 30 **DOC: [So are they hur:t, (.) when you:**
 31 **(0.8) touch around it, ((pointing to leg wound))**
 32 (0.2)
 33 PAT: Uh- er- No:, [not- not ye:t no[::, ((touching leg))
 34 DOC: [No, [No. No,

The physician, however, does not take this up, and instead moves to history-taking about the leg wound in particular, asking “how many day you have this” with stress on “this” and a point to the patient’s leg in line 23. The patient answers the question with “oh that’s going on already (about) almost two weeks” in lines 24-25. On its face this answer aligns with the question’s focus on the leg wound. However, it also registers a shift from the patient’s prior trajectory of talk, which was focused on problems like this more generally, rather than on the leg would in particular. This shift is

achieved in two ways: first, through the turn-initial “oh,” which registers the unexpectedness or inappropriateness of the physician’s question (Heritage 1998). Second, the patient’s deictic “that,” coupled with a gestural shift from pointing at his hand to pointing at his leg, marks the wound as at some distance from the patient’s perspective. In this case the distance is a figurative one, between what the patient is currently talking about (wounds that he gets easily in general, including on his hands), and what the question is about (the leg wound). This combination of turn design and embodied behavior indicates, however subtly, divergence between the physician’s emerging line of inquiry and the patient’s concern.

The physician maintains focus on the leg wound by taking up the patient’s answer to his question, requesting confirmation that the problem has been ongoing for “two weeks?” in line 27. However, in overlap with this the patient adds “and it started like just a little scratch, barely the skin” while pointing at his hand. This disaligns with the physician’s attempt to maintain focus on the leg wound in particular and returns to what appears to be the patient’s primary focus, that he gets wounds like this from minor actions like rubbing his skin. In these early phases of this patient’s visit, divergence is observably emerging between the physician’s focus on the leg wound *per se*, and the patient’s concern about a potentially more systemic problem.

The physician inspects the wound, but before delivering a diagnostic assessment the discussion is sidelined by other issues. In the beginning of the following extract the physician is summarizing action items from these other topics, recommending in lines 1-5 some medicine for controlling the patient’s blood pressure. The patient merely shrugs at this but nonetheless the physician moves on, returning to diagnose the leg wound: “and your leg may have some varicose veins” in lines 8-10.

(6b) PCT 11-05 Diagnostic assessment into counseling

1 DOC: So toda:y, (0.8) we want you to take some (0.5)
2 medicine?

3 (1.0)
4 DOC: For your (1.2) control of blood pressure.
5 (1.2) ((PAT shrugs))
6 DOC: Ka:y,=
7 PAT: =°ehh°
8 DOC: **And u:h (.) your leg,**
9 (0.5) ((PAT nods))
10 DOC: **May have som:e varicose veins.**
11 (0.2)
12 DOC: **Over here, ((gestures to leg))**
13 (0.5)
14 PAT: Varicose vein.=[Ye- yes.
15 DOC: [Yeah.
16 DOC: **So the:y (0.5) make your skin. (1.0) when they**
17 **get injured. (0.5) very hard to heal.**
18 (1.2) ((PAT nods))
19 DOC: Okay,
20 PAT: Ye::[s,
21 DOC: **[We're gonna- (.) have- (0.2) nur:se put the**
22 **betadine on you, put the dressing for you, ...**

The physician pursues response with an increment “over here” in line 12, in response to which the patient does a partial repeat “varicose veins” in line 14. This receipt and acknowledges having *heard* the diagnosis, but makes no claims about understanding or acceptance. The subsequent “yes” does move toward agreement, but in the context of the partial repeat may itself be hearable as agnostic with regard to understanding or acceptance. The physician then expands his assessment by explaining that varicose veins “make your skin... when they get injured... very hard to heal” in lines 16-17. This explanation ties back to the patient’s concern about how his wound has persisted for two weeks. The patient nods in response, but the physician treats this response as insufficient and pursues acceptance with a rising-intoned “okay” in line 19. As soon as the patient agrees with “yes” in line 20, the physician moves to treatment of the wound.

At first glance the physician’s diagnosis, which is expanded to include an explanation tying directly to the patient’s presentation, and his subsequent course of action to treat the wound address the patient’s problem. However, the problem attends only to the patient’s legs, sidestepping the patient’s orientation to his problem as more systemic in nature. Indeed, this is what the patient returns to in his subsequent resistance, illustrated in the following extract. The first instance of

resistance occurs sometime later, when the physician is about to take the patient's blood pressure.

The patient repeats his earlier comments that he gets wounds like this that start with a scratch or bruise and end up not healing for two or three weeks (lines 4-9).

(6c) PCT 11-05 Counseling

1 DOC: Stay on low salt, (0.2) we're gonna check your
2 cholesterol also today. ((getting arm cuff))
3 (0.5)
4 PAT: -> (An- an-) () my skin doctor it's worse than a
5 -> baby's skin:=like I tell you I scratch, [.hhh
6 DOC: [Mm hm,
7 PAT: -> and I get a brui:se, .hh and a little bitty s-
8 -> scratch, and I bleed? (0.8) and then I have a:
9 -> (.) a scab for two three weeks::,
10 DOC: Mm hm,
11 PAT: It's:::
12 **DOC: E- It's especially worse on the le:g. You kno:w,**
13 PAT: Tha[t's:
14 **DOC: [The leg take longer time to: heal,**
15 (0.8)
16 PAT: °° () °°
17 (1.2)
18 PAT: E:h (that's I say well,) ((shrugs))

The physician responds to this by again returning to his focus on the patient's legs with "it's especially worse on the leg" in line 12 and a reiteration of this explanation that the patient's legs "take longer time to heal" in line 14. The patient shrugs this off, and in subsequent lines the physician returns to taking his blood pressure and moves toward closure, calling the nurse for a blood test and to dress the patient's leg wound (lines 1-5 below). The blood test he is referring to here is routine lab work to check the patient's cholesterol, among other things.

(6d) PCT 11-05 Moving toward Closing

1 DOC: ((talking to NUR on phone)) Yeah a patient on room
2 nine, u::h he will need a blood te- u:h blood test?
3 And also: o:n=uh (.) dressing for the: (0.2) the::
4 small ulceration on the foot. (0.2) So: it needs a
5 clean dress, with uh (paper tape.) ((hangs up))
6 (1.0)
7 PAT: -> But it has nothing to do with my blood doctor,
8 (2.0)
9 **DOC: No,**
10 (0.5)
11 **DOC: But basically we're gonna check your blood test**
12 **also,**

13 (3.0)
14 DOC: Check for your blood count,
15 (1.0)
16 DOC: Your blood sugar, your cholesterol?
17 (0.2)
18 PAT: Ri:ght.

When the physician hangs up the phone the patient adds “but it has nothing to do with my blood doctor” in line 41. The “it” in this utterance is a locally subsequent reference term (Schegloff 1996) potentially picking up the physician’s own talk about the leg wound when he was on the phone with the nurse, but also tying back to the patient’s prior course of diagnosis resistance. The physician disconfirms with “no” in line 43 and then pivots to list the things the blood test *will* check and orienting to that as the patient’s meaning when asking about his “blood.” The “but” preface also suggests that, if the physician is wrong, he is nonetheless checking the patient’s blood, so there is a kind of appeasement quality to this pivot as well. The patient takes this up with “right” in line 52, declining to treat the physician’s answer as news – or as an answer to his question – (Gardner 2007; Hutchby 2020) however this is the end of talk about the wound.

In his first instance of diagnosis resistance (lines 4-9), the patient repeated a description of an aspect of his illness, observably returning to his original concerns and orienting to the physician’s divergence from them, but without further revealing the source of his concern. The second instance of resistance (line 41), however, suggests that the patient is specifically concerned that the reason he gets wounds like this has something to do with his “blood.” This concern was not raised at any earlier point in the visit, and yet once it occurs, we can see that it was likely underlying much of the patient’s talk throughout the visit. Indeed, although this case represents one of the more subtle ways a diagnostic assessment may diverge from the patient’s presentation of the problem, the patient’s later resistance renders the resulting gap between the patient’s concerns and how they’re being addressed more observable than usual. Here, the patient is concerned about some systemic problem with his blood that may cause easy injuries that are difficult to heal, and he can see, by the time he’s

in counseling, that he will likely leave the doctor's office without that concern having been addressed unless he intervenes.

4.4.1.7 Pivoting away from Diagnosis towards a Divergent Course of Action

The following extract represents a compelling subset of cases where a patient reveals, with varying degrees of explicitness, a desire for diagnosis or diagnostic assessment; the physician engages in fairly straightforward (non-divergent) information-gathering; but then the physician pivots away from diagnosis and pursues some other course of action in the shift to counseling, displaying an assessment that diagnosing the problem is not clinically relevant. Subsequent resistance highlights and is occasioned by this gap in participants' orientations to the relevance of diagnosis versus other courses of action. In some cases, the physician moves away from diagnosis altogether (this is exemplified in Extract 8 below), but in others, as in the extract analyzed here, the physician shifts *what* they diagnose, neglecting a symptom the patient oriented to as of central concern.

This patient suffers from a blood inflammation disorder called Churg-Strauss syndrome, which restricts blood flow to tissues and organs and can cause permanent damage. He walks with elbow crutches and refers throughout his visit to the work he must do to "lift his leg," by which he means using his arms to help lift his leg up. In this visit he presents with a primary concern surrounding a "snap" he heard in his elbow while doing this, and subsequent pain and swelling. At the very beginning of the visit the physician solicits a problem presentation with "what's this I heard a snap" in line 1. This design conveys prior knowledge of the patient's account of his problem, perhaps from a message to the doctor, notes in his file, or communication from the intake nurse. It clearly orients to the "snap" as a central reason for the patient's concern and solicits expansion. The patient aligns with this orientation, describing the snap. He says "it happened twice" in line 6, and then explains what "I heard a snap" means – while lifting his leg up, he heard a snap "like a chicken

leg thing” in his elbow (lines 13-17). Comparing the sound to a “chicken leg thing” suggests a theory of the problem as related to a bone or ligament that might “snap” as a one might do to a chicken leg while eating.

(7) AMH 02-03 Problem presentation through assessment

1 DOC: -> So (1.0) What's this I heard a snap.
2 (1.8)
3 PAT: Yea:h [we:ll.
4 DOC: [What is tha:t.
5 (2.0)
6 PAT: -> °It happened.° It happened twice.
7 (0.5)
8 DOC: What happen[ed.
9 PAT: [My physical therapist looked at it
10 (didn't see anything).
11 (0.5)
12 DOC: Uh huh,
13 PAT: -> It it happened twice.=n'- I went- (0.2) >I was<
14 -> (1.0) helping my le:g up like this, (0.2)
15 DOC: Yeah.
16 (0.8)
17 PAT: -> [^An:d I heard a snap like a chicken leg thin:g'n
[(PAT touching his elbow)
18 DOC: °Let's see° ((leaning in to examine elbow))

As the patient gestures toward his elbow, which is visibly swollen, the physician leans in to begin examining it, which he continues to do throughout subsequent lines until he delivers a preliminary diagnosis much later (shown below, line 53). By leaning in the physician conveys that he’s heard enough of a presentation to inform a move to examination and treats the “snap” as having been sufficiently explained. During this, the patient continues his problem presentation, repeating that “it happened again” in line 21, and adding that he “had puss comin’ outta here for a while” in line 25, again gesturing toward his elbow. In contrast to the “snap,” which is situated as the primary driver of the patient’s story, this symptom description is added as merely one part of that story. This is accomplished primarily in how it is delivered – relatively quietly, with no pitch reset and no gaze at the physician, and no gestural or intonational orientation toward this as particularly unusual or worrisome. Moreover, by initiating the turn with “and,” the patient builds this as a continuation of his prior turn “it happened again” in line 21, and thus casts it as merely a

characteristic of the second time he “heard a snap,” rather a discrete item of concern.

18 DOC: °Let's see° ((leaning in to examine elbow))
19 PAT: And [uh
20 DOC: [(>You've got a-<)
21 PAT: -> And it- it happened again:,
22 (0.8) ((DOC palpating elbow))
23 DOC: >Sorry<
24 (0.5)
25 PAT: -> An: [I had puss comin' outta here for a whi:le,
26 DOC: [(This side is-)
27 DOC: Puss?
((omitted lines, DOC getting the story straight))
28 DOC: You're saying that (.) when you heard the po:p (0.2)
29 and you had pain.
30 PAT: Yeah.
31 DOC: You let that try to heal.
32 (1.0)
33 PAT: [Yeah.
34 DOC: [But then you got swelling,
35 (1.0)
36 PAT: -> Well I wouldn't say out of contro:l, an:d
37 (0.8)
38 DOC: Oka:y,
39 PAT: -> It's just I didn't have strength: (0.2) to lift the
40 -> le:g anymore.
41 (1.0)
42 PAT: S[o: I just let it (0.2) (g-)
43 DOC: [.t .hh

The physician, in contrast, treats the presence of puss as noteworthy, responding with a request for confirmation accomplished through the single word “puss” produced with extra emphasis and strong rising intonation in line 27. In intervening omitted lines there is some repetition as the physician gets the patient’s story straight. This is what the physician is summarizing in lines 28-34 – that the patient “heard the pop,” had pain, “let that try to heal,” and then “got swelling.” In response to this last item the patient downgrades the severity of the swelling with “well I wouldn’t say out of control” in line 36, and then pivots to the fact that he “didn’t have strength to lift the leg anymore” in lines 39-40. By initiating this with “it’s just,” the patient casts his loss of strength as an alternative source of concern, relative to the swelling he downgraded in his just-prior turn. By focusing his problem presentation on the “snap,” minimizing his description of puss, downgrading his concern about swelling, and showing concern instead for a loss of strength, the patient

observably orients toward the “snap” and whatever effect it had on his strength as his primary source of concern, relative to any swelling or puss. The physician, however, who showed great concern over the puss, now focuses on *that* aspect of the problem as he shifts into counseling by suggesting he “put a needle in and make sure there isn’t still fluid in there” in lines 51-52.

42 PAT: S[o: I just let it (0.2) (g-)
 43 DOC: [.t .hh
 44 DOC: So- (0.5) [I-
 45 PAT: [I've- (.) [()-
 46 DOC: [I would suggest that if this is
 47 still: u:m (1.0) a little red does this hurt at all?
 48 (0.5)
 49 PAT: No.
 50 (0.2)
 51 DOC: >I mean< I would suggest that I just put a needle in
 52 and make sure there isn't still fluid in there,
 ((omitted lines, DOC explains this, PAT accepts))
 53 DOC: It's probably a superficial thing, (.) u::h you probably
 54 got a wh- you know olecranon: uh- bursitis from fluid in
 55 the joint there, .hh and then you probably got a little
 56 superficial skin infection or somethin' I don't know. .h
 57 'Cause if you had a joint infection: (.) I would expect
 58 it to: (.) have been a lot more serious.
 59 PAT: I see.
 60 DOC: Yeah.
 61 (0.5)
 62 PAT: And the snap?
 63 (0.2)
 64 DOC: .h Well the- who- who knows what the sn(h)a(h)p was.

In the intervening lines the physician explains what is involved in this procedure, and the patient accepts. Following this, the physician delivers a diagnostic assessment, saying “it’s probably a superficial thing” in line 53 and then explains that he probably got “olecranon bursitis from fluid in the joint there” and a “superficial skin infection” in lines 53-56. Olecranon bursitis is a fluid-filled pouch at the elbow, resulting from trauma or infection. Thus, the entirety of the physician’s diagnostic talk focuses on the swelling and puss in the patient’s elbow, but not the potential underlying cause, i.e., the “snap.”

This assessment is observably divergent from the patient’s perspective, as it is focused on a symptom the patient has observably downgraded, and entirely avoids the symptom the patient cast as his central concern. Indeed, this is what the patient directly challenges in his diagnosis resistance

in line 62: “and the snap?” The physician responds with a dismissive display of uncertainty “well who knows what the snap was,” explicitly revealing his choice not to address the snap. We learn later that the patient’s condition, which the physician knows about, makes him prone to muscle and tendon tears; he has already had multiple of these, and he is concerned that this “snap” is another one. This is a particularly illustrative case because the gap between the patient’s concerns and how the physician is addressing them becomes explicit later in the visit: the patient is concerned that he’s experienced yet another tear associated with his chronic condition, and he can see, by the time he’s in counseling, that he will likely leave without that concern having been addressed unless he intervenes. Such cases are useful for probing exactly what may be underlying diagnosis resistance in cases where patients are reticent to be so explicit.

4.4.1.8 Patients Giving Mixed Signals

Even in cases where patients do work to demonstrate a particular project, or when divergence begins to observably emerge, it is not always clear what a patient’s project, hypothesis, or other relevant concern motivating the visit *is*. In some cases, patients may even work to conceal their concerns or come to them in a round-about way, particularly if they are potentially problematic. In other cases, patients may go down multiple pathways when presenting their problem, leading the physician to have to choose the most relevant line of inquiry or course of action to address the patient’s problem, potentially neglecting another one of equal (or perhaps greater) concern. This extract is characterized by all of these features.

In the beginning of this visit the patient raises multiple concerns in succession. Her second agenda item is that, as she says, “I need a handicap placard” (not shown). When the physician pursues the reason for this she pivots slightly, saying “I need to see Doctor ((name)) about my foot again, because it just constantly comes back” (not shown). This kind of presentation is potentially

confusing for physicians, as it presents two potential agendas related to a single problem: getting a placard and getting the physician to investigate this problem himself. Indeed, this type of presentation, where a patient casts a concern as treatment-related but then more subtly reveals a desire for diagnostic investigation, is not uncommon in cases where patients re-present an acute problem that has already been addressed by another physician. It may be the case that patients are dissatisfied with the diagnostic inquiry or assessment of their problem, but are cautious about questioning it directly, and so instead frame their motivation for bringing it up as one related to treatment. In any event, such presentations present potential dilemmas for physicians in assessing the most appropriate way to address the patient's concerns.

After first focusing on other problems on the patient's initial list, the physician comes back to the issue fifteen minutes later, in line 1 below. He solicits a description of the problem, focusing on the handicap placard with "what's limiting you right now" in line 4. The patient responds with a conforming answer in lines 6-9, describing how she has difficulty walking "a distance" because the bottom of her feet "just kinda just hurts."

(8) AMH 01-09 History-taking through diagnostic assessment and counseling

1 DOC: A:nd so tell me- so- so let's focus: (0.2) the last=uh
2 few minutes on thee:=uh (1.0) so- (0.5) so tell me about
3 this:=u:h (1.5) u- disability car:d.=Tell me what's
4 thee:=uh (1.0) what's limiting you right now.
5 (0.8)
6 PAT: Well, the (0.2) the:: (0.5) walki:ng, if I have to
7 walk a distance. (0.2) And I just- (0.5) .hh <y'know
8 my- (0.2) my- the bottom of my feet. jus:t (1.0)
9 kinda: just hurts.
10 DOC: Yeah.
11 PAT: Because (0.5) I asked them: to take a x-ray of it
12 -> (0.2) because it looks like (0.5) it's something else.
13 (0.2)
14 DOC: °Uh [huh°
15 PAT: -> [But he said it's no:t (0.2) it's jus:t (0.2) y'know
16 -> (0.5) dead skin: but (0.2) I'm like (0.2) huh? (0.8)
17 -> Why does it keep coming ba:ck (0.2) after you do it
18 -> (1.0) it comes ba:ck within a week.
19 DOC: Okay.

But then, in a pivot mirroring the one at the beginning of the visit, she shifts to a description

of the problem vis-à-vis difficulties with a prior physician's diagnosis, adding "I asked them to take a x-ray of it because it looks like it's something else" in lines 11-12. By adding "it looks like it's something else" in line 12, the patient directly challenges the prior physician's diagnosis; she further unpacks this challenge, saying "but he said it's not... it's just dead skin" in lines 15-16, and then questions that diagnosis with "I'm like huh? Why does it keep coming back..." in lines 16-18. This presents the physician with potential projects in addition to the request for a handicap placard: pursuing diagnostic testing, and more generally pursuing re-investigation of the problem and possibly rule-out of "something else."

The patient further unpacks what she means by "why does it keep coming back" and provides additional evidence in support of her challenge to the prior diagnosis by describing her treatment routine in lines 20-31 and adding in line 33 "nothing helps."

17 Why does it keep coming ba:ck (0.2) after you do it
 18 (1.0) it comes ba:ck within a week.
 19 DOC: Okay.
 20 PAT: He's got me soaking my feet twice a da:y, (0.5) I do it
 21 in the morning when I get u:p, (0.8) and I do it (0.2)
 22 in thee:: (0.2) u:h mid afternoo- u:h y'know evening.
 23 (0.8)
 24 PAT: Before I go to be:d.
 25 (0.5)
 26 PAT: A:n'u:h (1.2) but that- (0.2) u:rea, (0.2) °urea,° (0.2)
 27 crea:[m,
 28 DOC: [Mm hm:..
 29 (0.8)
 30 PAT: A:nd (0.5) sometimes I use vasesli::ne, sometimes I use
 31 vicks vaporu:b, .hh whatever I can think to make it soft.
 32 (1.8)
 33 PAT: -> Nothing helps.
 34 (0.2)
 35 DOC: Ok[ay.
 36 PAT: -> [but- and it gets (1.0) thi- it's only on this le:g
 37 though.
 38 (0.2)
 39 PAT: -> It's only on the right leg.
 40 DOC: O:kay.
 41 (0.8)
 42 PAT: -> And=u:m. (1.5) I don't know. Jus:t (2.8) ((rubs eyes, then
 43 gestures palms facing in front of her, pulsing))
 44 ehhh

The physician takes this up and treats the patient's turn as complete with "okay" in line 35,

but the patient expands her telling again with “it’s only on this leg though... it’s only on the right leg” in lines 36-39. She then bids for closure of her problem presentation by adding “I don’t know” and a trailed-off “just” in line 42, followed by an eye-rub. She also adds a gesture mimicking pushing something away in front of her; it’s not clear what this gesture is meant to convey, but it certainly aligns with a general sentiment of challenging or pushing back against something – in this case, perhaps, the other physician’s diagnostic assessment.

Despite the patient’s work to cast her problem as one of diagnosis, the physician stays his course, returning to his original question (“how is it limiting your walking” in line 45), pursuing an answer to *that* question and treating everything else the patient has said so far as not relevant information for his agenda. This shows some departure from the patient’s ongoing project for renewed inquiry into her problem. But it’s important to note that, unlike in other cases of obvious divergence, it was the patient herself who initially framed her concern as related to getting a handicap placard, and the physician is pursuing that concern.

42 PAT: And=u:m. (1.5) I don't know. Jus:t (2.8) ((rubs eyes, then
 43 gestures palms facing in front of her, pulsing))
 44 ehhh
 45 DOC: **And so- e:- 'n tell me abou:t u:m (0.2) how i- how is it**
 46 **limiting your walking.**
 47 (2.0)
 48 PAT: We:ll sometimes it hurts (0.5) that ba:d.
 49 (0.5)
 50 PAT: Just coming from the (0.5) parkin:g,
 51 DOC: Mm hm.
 52 PAT: in front of my door.
 53 DOC: Mm hm.
 54 PAT: to my house.
 55 DOC: °Mm hm.°
 56 (0.5)
 57 PAT: °Y'kno:w bu:t°
 58 (0.5)
 59 PAT: I don't know. I probably don't even need it.
 60 (0.8)
 61 PAT: You kno:w.
 62 (1.2)
 63 PAT: I was thinking about it but
 64 DOC: Sure.=
 65 PAT: =Mm:. (0.2) °I don't know.° ehhh

The patient answers the question, saying that sometimes her foot “hurts that bad” in line 48,

i.e., bad enough to merit a handicap placard request. She adds an example of “how bad” – “just coming from the parking...in front of my door... to my house” – to which the physician only responds minimally, without taking up her answer and moving on to some next item on his agenda. The patient treats this silence as a potential indicator of impending refusal of her request by reversing course and saying “I don’t know. I probably don’t even need it... I was thinking about it but I don’t know” in lines 59-65.

In response to this the physician says he’s “open to the idea if it’s really a disability” in lines 66-69, potentially challenging the patient’s claim to disability-level pain. However, he then adds “I kinda wanna see if there’s something we can do also about the pain” in lines 72-73. This pivot displays an orientation to the patient’s prior illness narrative as indicating a problem not with disability *per se*, but with an unresolved pain problem. On one hand, this move may be seen as departing from the patient’s bid for a placard. However, given the patient’s prioritization of detailing her pain *as* an unresolved medical problem, rather than a bid for a handicap placard, this move also moves toward what is emerging as the patient’s “real” concern.

65 PAT: =Mm:. (0.2) °I don't know.° eh hh
66 DOC: Well I- I wish we could (2.0) .th I'm open to the idea
67 if it's really (0.5)
68 PAT: [Mm hm,
69 DOC: [a disability:
70 (0.5)
71 PAT: Yea[:h.
72 DOC: [but- (0.8) I kinda wanna see if there's something we
73 can do: (0.2) [also about the pain.
74 PAT: [Ri:ght. Well he's gonna u::m (0.5) .pt
75 he's gonna check it. (0.5) and=u:m (0.2) make sur:e.
76 (0.8)
77 PAT: Tha:t u:m (0.8) I asked him to do the x-ray.
78 (0.5)
79 PAT: And he said okay the next time I come i:n .hh he would do
80 an x-ray on my foot.=
81 DOC: =Oka:y,

Somewhat unexpectedly, then, the patient pushes back against this and undermines her own prior portrayal of the other physician as unwilling to do an x-ray, saying that he has indeed already

agreed to “check it” (line 75) and that “he said okay the next time I come in he would do an x-ray on my foot” (lines 79-80). This suggests that the physician’s new tack, of pursuing treatment rather than a handicap placard, does not yet address the patient’s underlying concerns.

The patient pivots the focus of her concerns again in line 82, adding that her aunt “just had her leg amputated” in line 82, which she initiates with “because.” Given its sequential and syntactic position vis-à-vis her prior comment that the physician agreed to do an x-ray, this is potentially hearable as providing the *physician’s* reasoning for doing an x-ray. But rather than continuing with some kind of comment on the physician’s reasoning (e.g., “so he wanted to make sure it’s not X”) she goes on to explain her aunt’s situation.

79 PAT: And he said okay the next time I come i:n .hh he would do
80 an x-ray on my foot.=
81 DOC: =Oka:y,
82 PAT: -> Becaus:e (1.5) my aunt just had her le:g amputated.
83 DOC: °Ooh.°
84 (1.2)
85 PAT: She's in a reha:b,
86 DOC: Y[eah.
87 PAT: [or whatever- (0.5) after they do it they send her: to
88 the rehab for whatever.
89 (1.8)
90 PAT: -> A:nd (0.5) she j- found out sheu was a diabetic.
91 (0.2)
92 PAT: I didn't know she was.
93 (0.5)
94 PAT: I knew she had cancer but I didn't know she was a
95 diabet[ic.
96 DOC: [Okay,
97 PAT: -> But they just amputated her le:g (0.5) and I don't want
98 -> that to happen (0.5) to me, (0.5) for the simple fa:ct
99 -> I'm telling you. This thing keeps (0.2) you know: what
100 PAT: I'm [saying, it keeps (0.5) the ski:n it's like (0.5)
101 DOC: [Yeah.
102 PAT: (0.5) this- (0.2) thumb.
103 (0.8)
104 PAT: This is the skin:,
105 DOC: Ye[ah.
106 PAT: [An' it just- (0.2)
107 DOC: g[rows again.
108 PAT: [(op-)
109 PAT: I[t grows again!='n it gets thick!
110 DOC: [Yeah.
111 (0.5)
112 DOC: Yeah.
113 PAT: And then sometimes it hurts when you walk!

114 DOC: °Mm hm°
115 PAT: Y'kno:w,

The patient says that her aunt was a diabetic in lines 94–95, and then links this back to her own problem by adding “I don’t want that to happen to me” in lines 97-98. This may begin to reveal what the patient’s underlying concern was when she said that the growth on her foot “looks like something else” earlier in the visit. Indeed, this patient has diabetes, and problems of the feet can lead to severe health problems, including amputations. She then repeats some of her prior symptom descriptions – that the skin keeps growing back and getting thick, and it hurts to walk, in lines 99-113 – framed this time as an account for her fear of amputation.

The physician responds to the patient’s concern about amputation by framing it within broader concerns about “the complications of diabetes” in lines 116-117, recommending “stronger control of the blood sugar” in line 120 and going to see a “diabetes doctor” who will “take some ownership” and “push you to get your diabetes better” in lines 123-136. This is the third tack the physician takes to address the patient’s concerns, with the patient having indicated that his first two may have missed the mark (pursuing a handicap placard and treating the pain).

113 PAT: And then sometimes it hurts when you walk!
114 DOC: °Mm hm°
115 PAT: Y'kno:w,
116 DOC: W'll the key: (0.2) way to preven:t (1.0) thee:
117 (0.8) complications, of diabetes?
118 PAT: Mm hm:,
119 (1.0)
120 DOC: is: (0.5) stronger control: of the blood sugar,
121 PAT: Mm hm:,
122 (4.0) ((tapping thigh, looking at PAT's foot))
123 DOC: .hh You know- We have a goo:d young: new: diabetes
124 doctor:.
125 PAT: [Mm hm,
126 DOC: [named u:h ((name)).
127 ...
128 DOC: I: would recommend (.) gettin' ya in to see him:.
129 (0.8)
130 DOC: Be:cau::se (0.8) I think he's gonna kinda take
131 some ownership.
132 (.)
133 DOC: An:d really push you.
134 (0.2)

It is noteworthy, however, that although the physician is still clearly oriented to the patient's issue with her foot – looking at her foot as he displays “thinking” in line 122 – his recommendation that the patient see a diabetes doctor is not about her foot issue *per se*, but about controlling her diabetes more generally. The patient responds minimally, if at all, to the increments of this recommendation, and the physician begins work to persuade her to accept the recommendation, using her concern about her foot as a reason with “if you get your diabetes better... your feet are gonna feel better,” in lines 135-137.

The elongation and rising intonation on “better” and the second “your” in line 140 cast this as the first item in a list of reasons the patient will feel better if she gets her diabetes in control. This recommendation to see a diabetes doctor is at least partially designed to address the growth on the patient's foot. The physician does not, however, explicitly link the two, and even observably avoids referring to the growth itself by more vaguely referring to *both* her feet (whereas she explicitly stated this is just on her right foot), and how they will “feel better.” The fact that the physician has begun making recommendations, rather than listening to the patient's story or soliciting more information, suggests that there has been a shift from information-gathering to counseling, and that this *is* his assessment of the patient's problem and how to most relevantly deal with it. Notably there has been little, if any, diagnostic investigation, and there is no explicit diagnosis here.

133 DOC: An:d really push you.
 134 (0.2)
135 DOC: To get your diabetes better,=If you get your
136 diabetes better: (1.2) you're gonna be:: in a
137 better- your feet are gonna feel better:,
 138 PAT: Mm hm.
 139 (0.2)
 140 DOC: Your[:
 141 PAT: [So you think it's because of the
 142 diabetes? my foot is like this?
 143 (0.2)
144 DOC: .t Well the growth I don't know about #that#.
 145 (0.5)
 146 PAT: Mm[:.
147 DOC: [Bu::t the other pains and do- the way to

148 **prevent (0.5) complications: (0.8) like (.)**
149 **am[putation,**
150 PAT: [Mm hm.
151 (0.5)
152 DOC: **is good control of blood sugar.**
153 PAT: Okay.

This case is a complicated one in terms of what underlying concerns have led the patient to bring up her foot pain, given the twists and turns of her description of her problem throughout the visit. There were some moments of observable divergence – for example when the physician pursued her request for a placard when she was clearly concerned about the problem itself – and other moments where the patient treated the physician as missing the mark, but for reasons that were less obvious. But it does eventually become clear that the patient is displeased with how her problem has been dealt with by a prior physician in terms of diagnostic inquiry/ assessment, and she is concerned about the potential link between her foot problem and diabetes complications. Throughout the visit she has presented – and repeated – specific details about her symptoms that might typically prompt diagnostic investigation. All of this suggests a general project toward diagnostic inquiry/ diagnosis of her foot *per se*. The physician’s ultimate assessment, then, is somewhat orthogonal to this project, and is another example of cases where physicians pivot away from diagnosis in pursuit of a different course of action.

Indeed, this is what the patient subsequently pushes back against when she explicitly requests a diagnostic assessment of her foot with “so you think it’s because of the diabetes my foot is like this?” in lines 141-142. This request forces the physician to make explicit his assessment (not unlike Extract 7 “well who knows what the snap was”), that diagnosing the growth on the patient’s foot is not clinically relevant to how he has decided to address her problem: “well the growth I don’t know about that” in line 144. He then takes up her concern about amputation as a means to return to his recommendation to see a diabetes doctor with “the way to prevent complications like amputation is good control of blood sugar” in lines 147-152. Despite the mixed signals from the patient early on,

there is a distinct push and pull here between participants' orientations to the relevance of diagnosing the patient's foot pain.

4.4.1.9 Summary

In this first part of my analysis, I have focused on cases where patients ultimately resist a diagnostic assessment. Although cases represent individual patients with distinct illness experiences and underlying concerns, and each visit unfolds in its own way in terms of how a patient presents their problem and how a physician investigates and assesses it, I argue that there is one overarching commonality among cases where patients ultimately resist a diagnostic assessment. That is: there is observable divergence between how the patient presents their problem and how it is ultimately investigated and assessed.

All of the cases I have shown exhibit the same parts of a divergence-resistance trajectory: a patient does work early on to cast their problem in a certain way; a physician's subsequent line of inquiry and assessment diverge from the patient's own assessment of the problem; and the patient's subsequent resistance is observably tied to how they initially discussed their problem.

The cases I have shown varied in terms of the lines along which divergence emerges; the explicitness of the patient's work to convey some aspect(s) of their assessment of the nature of their problem; the intensity and directness of the emerging divergence; and the degree to which the patient's subsequent resistance explicitly renewed or even revealed more about the patient's original concerns. But what these cases share in common, as I argue all cases of resistance preceded by divergence share, is that a through-line *is* observable from divergence to resistance, such that the patient's resistance observably emerges out of the gap between the patient's original concerns and how the physician is addressing them during counseling.

In the AMH dataset, nearly three-quarters of the 70 cases containing diagnosis resistance can

be seen to emerge out of the kinds of divergence described here. The remaining cases of resistance come in contexts more closely resembling visits where resistance does not occur, described in Part 2 of this chapter. In some of these, resistance is locally emergent, for example when a patient's concerns are explicitly addressed but then during counseling the physician says something that minimizes the problem or otherwise threatens the patient's face in terms of the legitimacy of their decision to come to the doctor, and the patient resists that.

In some cases, however, there are no observable problems or precursors to the patient's resistance. These cases are themselves illuminating in terms of the proposed relationship between divergence and later resistance. Consider Extract 9.

In this visit the patient presents with persistent hip pain. He gives a rather extended problem presentation, but one which for the most part consists only of symptom description and narrative. During history-taking the physician asks if the pain runs down the back of his leg, to which he responds, "I was kinda hoping it would so I could call it sciatica I guess, but it doesn't really go below here" (not shown). This displays some orientation to the problem as mysterious and/or potentially more serious than sciatica, such that a later diagnosis of sciatica could be heard as divergent, but this is not what the diagnosis is. There is no other evidence of a particular project or theory of the illness. The physician shifts into counseling with a recommendation for an x-ray to "take a look at the hip joint itself" (not shown). She then explains possible outcomes of the x-ray – arthritis and hip flexor tightness. Her talk surrounding this diagnostic test treats the need for an x-ray as legitimate and orients to both outcomes as equally likely, and thus does not overtly threaten the legitimacy of the patient's decision to come to the doctor.

During a lull in the talk when the physician is entering her orders for the x-ray in lines 1-5 below, the patient adds "my wife is worried because our neighbor started with these symptoms and a year later he died" in lines 6-7. The patient mitigates his incursion into the domain of diagnostic

reasoning in two ways here. First, he offloads responsibility for his worry about the seriousness of his problem on his wife via a third-party attribution (Heritage & Robinson 2006a). Second, he alludes to a candidate diagnosis without actually stating one; it's fairly surprising for someone to go from hip pain to death, and by merely stating that he "died" without naming the actual cause of death, the patient's turn begs the question, and puts the physician in a position to *solicit* a candidate diagnosis. After responding with a pouty "oh" in line 9, the physician indeed solicits a cause of death/ candidate diagnosis with "from what?" She also orients to the possibility that the patient didn't say because he doesn't know with "did sh- do you know? or..." and the patient answers with "esophageal cancer that had traveled to the bones" in lines 13-14.

(9) AMH 05-04 Counseling

1 DOC: °So (we're gonna) do tha:t,° ((moving to computer))
 2 (0.5)
 3 DOC: °#(Let's) see.#°
 4 (1.5) ((DOC typing))
 5 DOC: °°((mutters as typing))°°
 6 PAT: -> My wife is- worried because our neighbor started
 7 -> with these symptoms and a year later he died.
 8 (0.5)
 9 DOC: O[h.hh ((pouting))
 10 PAT: [So, ((laughs))
 11 DOC: .h From #wh[at?=did sh- do [you know kno:w?or:
 12 PAT: [(eh) [U:m
 13 PAT: -> Y:ea:h he ha:d=u:h (.) esophageal cancer that had
 14 -> traveled to the bones,
 15 DOC: .h O::h [gee:ze. [#Oh# ma:[n.
 16 PAT: [Y'know, [So. [(It's very)
 17 (0.8)
 18 DOC: Well you can tell'r we're gonna do an x-ray so
 19 we'll definitely be able to- (0.8) look at
 20 that but I don't think (.) #e- that's wha-
 21 [what is going on.#
 22 PAT: [((shrugs)) (That's her.)
 23 DOC: #Yeah.#

This is indeed a serious underlying concern the patient has about his hip pain, and one that the physician has not explicitly addressed. But the patient did little, if anything, to reveal this concern earlier in the visit. Thus, although the diagnosis resistance itself reveals a gap between the patient's

concerns and how the physician has addressed the problem, only the patient would have been aware of this gap. Nonetheless, the lines along which patients resist in cases like this suggest that the same types of divergence underly that resistance as in cases where the patient's perspective is at least partially observable.

4.4.2 *Contrasts with Cases of No Resistance*

In this second part of my analysis, I focus on cases where patients do *not* ultimately resist a diagnosis, examining differences in how they unfold that could further explain the interactional processes leading to resistance. A few of these can at most be characterized as “no observable divergence.” These cases are relatively uninformative because, as I've shown, divergence can sometimes be extremely subtle and in some cases is only noticeable or analyzable once resistance occurs. Most cases, however, can be characterized by the *presence* of interactional patterns that provide telling contrasts with cases where resistance occurs (more than five-sixths of the 52 cases of no resistance). These mostly consist of *convergence* between patients' and physicians' assessments of the patient's problem, e.g., the patient's diagnostic theory is confirmed or they are given some treatment, test, or referral they were seeking; the physician treats the patient as an expert on their condition; the physician delivers a diagnostic assessment that is as serious as, or more serious than, the patient oriented to the problem; the physician recommends diagnostic testing, framing this testing as clinically legitimate; or the physician delivers an indeterminate or no-problem diagnosis after the patient does some work to let them “off the hook” in terms of diagnosing the problem. I illustrate each of these in this section.

The problem with these findings is that they suggest patient resistance can only really be mitigated under certain conditions, where the clinical picture happens to converge with the patient's expectations or theories (or the physician gives in to patient expectations regardless of clinical

indication), or the patient happens to let the physician off the hook. As I show at the end of this section, however, there is a small subset of cases where there *is* observable divergence but no later resistance; in these cases, physicians have done work to bridge the resulting gap by explaining their clinical reasoning in a way that ties to the patient’s concerns. This may point to one way physicians can mitigate resistance even in contexts of divergence. I discuss the upshot of these findings more at the close of this chapter.

4.4.2.1 Meeting Patient Expectations

The first extract illustrates a case where there is obvious alignment between the patient’s displayed project for a particular outcome and the physician’s diagnostic assessment. In lines 1-4 the patient describes a problem with urinary incontinence (framed as “my urine problem,” which orients to it as something the physician is already aware of), for which she needs to use many pads to absorb over the course of each day. She is about to move on to the upshot of her symptom description with “so I-” in line 6 but cuts herself off as the physician requests confirmation that “it’s like the urine leaking, leaking,” in line 7. The patient confirms by repeating the reduplicated “leaking, leaking” and a grimace in line 8, and then returns to her prior move to her request with “so I wanna get somebody to talk to” in lines 11-12.

(10) AMH 04-08 Problem presentation into counseling

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((10 min in, PAT looking at list, moving to next item))
1  PAT:    U::h (.) My urine problem is: (.) pretty heavy:
2          an' I have to chan:ge (0.2) .hmt I have the pa:ds'n
3          then I put a kotex pad on top of that .hh and I
4          have to change them four or five times a day.
5  DOC:    Okay.
6  PAT:    So [I-
7  DOC:    [It's like the ur:ine le_aking, le_aking,
8  PAT:    .pt ((grimacing)) Le_aking. Le_aking.=
9  DOC:    =Mkay.
10         (0.2)
11 PAT:    -> .pt .hh So: (.) u::m (1.0) I wanna get somebody to
12         -> (0.2) talk to:.<U:h I think Boston: (0.5) Boston
13         -> had come-<I brought it in: last time.=Had come up

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to talk to” as opposed to anything to do with the new laser therapy. She also addresses the patient’s displayed lack of knowing about who the appropriate specialist may be by naming the specialist before agreeing to the referral. She thus fulfills both aspects of the patient’s request – she informs her about the appropriate specialist and agrees to a referral.

The patient responds to this with three “ohs” in line 22, treating the existence of specialists as new information for her (Heritage 1984b). She then agrees with the physician that they are the appropriate candidates for “someone to talk to” with “yes” in line 24 and a move to write this down in lines 26-31. Finally, she explicitly accepts and positively assesses this outcome with “great” in line 33 and a request for “some names” in line 35. This case thus illustrates clear convergence along the lines of the patient’s stated desire to “get someone to talk to.” Other cases of clear convergence include recommending tests or treatment the patient observably pushed for.

4.4.2.2 Agreeing with the Patient’s Candidate Diagnosis

Another context where there is observable convergence between physician and patient is when a diagnostic assessment straightforwardly agrees with or confirms the patient’s candidate diagnosis. In many cases, as in this extract, a physician confirms the diagnosis in the visit. In other cases the physician recommends testing geared toward the patient’s hypothesis.

In this visit the patient has presented multiple problems, including concerns about a hernia and prostate issues. This patient has a condition affecting his short-term memory, and so he has a companion (COM) along with him. Toward the end of the visit, the companion brings up an additional concern by reminding him “one more... your foot” in lines 1-3. The companion then presents the problem to the physician as “some type of fungi on the left foot” in line 5, a candidate diagnosis.

(11) AMH 01-17 Problem presentation through counseling

1 COM: On:e more.
2 (0.8) ((COM gazing at PAT))

3 COM: Your foot.
4 (0.8) ((COM pointing at PAT foot))
5 COM: -> Some type (.) of fungu-gi: on the [left foot.
6 PAT: [.t O:h yea::h.
7 (0.5)
8 PAT: Yea:h.
9 COM: That you can check doctor,
10 PAT: Mm hm,
((omitted lines; narrative of discovery; exam))
11 DOC: **Ah.** ((bending over PAT's exposed foot))
12 (0.2)
13 DOC: **Yeah.**
14 (0.2)
15 DOC: **Foot fungus.**
16 (.)
17 DOC: **Mm hm?** .th So:- so we can: [give you=there's
18 PAT: [You mean there's a
19 fungus amongus?
20 DOC: ((lau[ghs])
21 COM: [((laughs))
22 DOC: So we can give you a topical medicine for that.
23 PAT: ^Woo hoo:::.

In the omitted lines the companion narrates discovery of the problem, and accounts for encouraging the patient to see the physician about it – that the physician “has medicines for that” (not shown). The patient then removes his shoe and sock and points at his toes, and the physician visually examines the foot. As he is still bending over the foot, the physician says “ah... yeah... foot fungus... mm hm?” in lines 11-15. This explicitly agrees with the companion’s candidate diagnosis in multiple ways. The “ah” in line 11 displays recognition of the problem as described by the companion, and the “yeah” agrees with her candidate diagnosis. The fully repeated diagnosis “foot fungus” asserts epistemic primacy in recognizing foot fungus (Heritage & Raymond 2012) (as does the design of this as a confirmation in the first place), but it observably repeats the word “fungus,” again highlighting agreement. The final “mm hm?” in line 17 redoes agreement and confirmation before moving into treatment talk. The patient makes a joke about a “fungus amongus” (interestingly not the only time this joke is made by a patient in the data) and then accepts the treatment recommendation with “woo hoo” in line 23.

Such cases may appear to be so unproblematic because the problem itself is so

straightforward and treatable. But it is hearably that way because it has been *cast* that way by both patient and physician, and because there is such overt agreement between the diagnosis and the candidate diagnosis. This visit would likely look different – and more resemble a case of divergence – if the patient had presented the problem, for example, as a bacterial infection, i.e., a disagreeing candidate diagnosis.

4.4.2.3 Treating the Patient as an Expert

Another way physicians address patient expectations is by treating the patient as the “expert” in terms of the most appropriate way to treat their health problem. This is most common in cases where the patient has some serious chronic health issue, e.g., HIV, although it must be noted that patients are not always treated this way and divergence can emerge when patients with extensive prior experience with some health problem attempt to assert the appropriateness of some outcome, but a physician does not align with their self-orientation as expert.

In this visit the patient suffers from a chronic health condition called Churg-Strauss (which restricts blood flow to tissues and organs and can cause permanent damage), as well as COPD (chronic obstructive pulmonary disease), but his primary reason for coming in is elbow pain (the “snap” and swelling from Extract 7), which he is worried may be a muscle tear related to the Churg-Strauss. During a hiatus in talk about that problem as the physician waits for a nurse to prep for a procedure to extract fluid from the elbow, the physician asks if there are other problems. The patient brings up “sinus infection and lung infection” in lines 1-2 below. He adds that “I usually call my lung doctor on this” in lines 6-7, and then accounts for not having called that doctor by casting the problem as non-worrisome because “I’ve been getting it up and it’s not super colored” in lines 10-12, suggesting no actual signs of infection and thus no need for antibiotics (Stivers 2002a, 2007; Filipetto et al. 2008). On the heels of this he adds what *is* the problem by saying “it is causing asthma

[another condition that can be caused by Churg-Strauss] in the morning pretty bad” in lines 15-16.

(12a) AMH 02-03 Problem presentation

1 PAT: Right no:w I'm struggling with: sinus infection:,
2 and lung infection.
3 DOC: Oka:y,
4 PAT: Kay?
5 DOC: (Did) some[one treating you,-
6 PAT: [I u- well I usually:: call: my:: uh lung
7 doctor on this,
8 (0.2)
9 DOC: °(Mm hm?)°
10 PAT: -> An:d u::h I haven't yet? becaus:e actually I've
11 -> (0.2) been getting it up, and it's not super
12 -> colored,
13 (0.2)
14 DOC: Ka:y,
15 PAT: U::h (0.5) it is causing asthma:, in the morning?
16 pretty ba:d?
17 DOC: Oka:y,
18 PAT: But I do: the nebulizer:, and I'm (pushing air now)
19 so: (0.2) I probably- (0.5)
20 DOC: Well [I-
21 PAT: [Probably at thirty five forty percent.
(DOC begins working on PAT's elbow, topic is tabled)

The physician then begins working on the patient’s elbow, and the topic is tabled. When the physician comes back to it, he initiates a physical examination where he listens to the patient’s lungs. He comments on what he hears with “you don’t move air that well anyway” in lines 1-2 below, orienting to the patient’s ongoing health problems but also revealing that he may be unable to distinguish evidence of a lung infection separate from what he’s hearing due to those conditions. He then explicitly casts himself as non-expert on the patient’s health conditions with “I don’t know your case that well as you know I just met you recently” in lines 4-7 before asking the patient to describe the extent of his prior experience with problems like this in lines 7-8 (“do you have pretty severe COPD though, do you get a lot of exacerbations”) and lines 10-11 (“how often do you get to where you need to use the nebulizer and maybe antibiotics”). This is the kind of question not asked, for example, of the patient with a history of asthma who was bidding for antibiotics in Extract 2, despite working to cast herself as expert.

(12b) AMH 02-03 Physical exam and further questioning

((DOC listening to lungs))

1 DOC: U:m (.) you kno:w- You don't air- you don't
2 move air that well anywa[:y,
3 PAT: [No.
4 DOC: -> U:m (0.5) do you: have- (0.2) I don't know your
5 -> case that well as you kno:w I just met [you
6 PAT: [Sure.
7 DOC: -> recently,=Do you have pretty severe COPD though,
8 -> do you get a lot of exacerbations?
9 (2.0) ((PAT looking away, "thinking" face))

10 DOC: -> How often do you get- (0.2) to where you need to
11 -> use the (0.2) nebulizer and maybe (0.2) anti[biotics.
13 PAT: [It's- it
com:es with (.) some kind of aggravating thing:, like
the flu:,
15 DOC: Sure.
16 PAT: Or thee=uh (.) or thee: (.) infection.
17 DOC: Yes.
18 PAT: So: (.) I've read up on: churg-strau:ss, an::d...
((omitted lines; explains his condition & steroid management))

The patient answers the question in lines 13-16, describing not *how often* but, relatedly, *under what conditions* he experiences exacerbations – that it happens with “some kind of aggravating thing like the flu or the infection,” returning to his prior candidate diagnoses. He then projects a longer telling by saying he has “read up on Churg-Strauss” in line 18, and in the omitted lines proceeds to explain how he’s worked with another physician on experimenting to see how low they can keep his level of steroid medication, which treats inflammatory conditions like his but with serious side effects, especially with use for an extended period of time and/or at high levels. At the low level he’s currently at, he experiences “break throughs,” which means the level of steroid in his system becomes too low to manage his symptoms. In line 19 he casts this as the probable cause of his current lung infection, in addition to the fact that “there’s fluid” in his respiratory system and he doesn’t “wash it out every day” in lines 20-21.

The physician, who has suspended all other activity and has been attentive to this telling, takes it up with two “yeahs” in line 22 and then, returning to his claim to non-expertise with “well I think the question that I have for you because I don’t know you as well” in lines 25-26, asks more explicitly for the patient’s opinion in terms of how to address his problem with “in terms of your

COPD... do you think you need a chest x-ray today” in lines 30-31. He quickly adds his own clinical opinion “cause I don’t think you do. I don’t think you have pneumonia” in lines 31-32. Although this asserts clinical expertise and disconfirms the candidate diagnosis implicit in the patient’s use of the word “infection,” it is distinctly different from other cases in how the physician asks the patient for his own opinion on clinical matters, treating him as having some level of expertise himself.

```

19 PAT:    So I broke throu::gh and I get these infections.=Cause
20         there's fluid (0.8) and I don't wash it out every
21         da[:y,
22 DOC:    [Yeah. Yeah.
23 DOC:    [So-
24 PAT:    [Which I probably shou:ld,
25 DOC:    -> Well I think the question: (.) that I have for you
26         -> because I don't know you as well:,
27 PAT:    [Yea:h you got it, don't [worry,
28 DOC:    [in terms of-           [in terms of your COPD.
29         (0.2)
30 DOC:    -> .h Is: (.) u::m .pt (.) do you think you need a
31         -> chest x-ray #today.#<'Cause I don't think you
32         -> do:. I don't think you have pneu[monia.
33 PAT:    [E::h not
34         really[::
35 DOC:    [The o[nly reason-
36 PAT:    [If you want to you ca::n:, [(but)
37 DOC:    [I don't
38         think we need to do it. I- [but I-
39 PAT:    [I haven't ha:d one
40         in quite- we::ll, [( )
41 DOC:    [I don't- the only reason to
42         do it, (0.2) is if we think you have pneumonia:=
43         and I don't think you have pneumonia=[.h I think
44 PAT:    ((shaking head)) [( )
45 DOC:    you have a COPD exacerbation.
         ((omitted lines; recommends to continue treatment
         but also update the pulmonologist))

```

The patient answers the question with a mitigated agreement with the physician’s assessment “e::h not really” in lines 33-34, adding “if you want to you can” in line 36. On one hand, this defers to the physician to make the final decision; but it also orients to the context as one of legitimate negotiation, which is unusual for the counseling phases of primary care visits. Just as the physician re-states “I don’t think we need to do it” in lines 37-38, the patient adds a potential reason to get an x-ray, presented from a position of expertise in terms of the timeline of his own illness and care,

with “I haven’t had one in quite-” in lines 39-40. Although this goes against the physician’s recommendation, again, it is produced in the context of shared decision-making enacted by the physician’s earlier request for the patient’s opinion. The physician re-states that “the only reason to do it is if we think you have pneumonia and I don’t think you have pneumonia,” adding “I think you have a COPD exacerbation” in lines 41-45. This casts the direction the patient was going, i.e., considering how long it’s been since his last chest x-ray, as irrelevant to the current decision-making, claiming primary expertise to frame the decision-making. But by using “we” in “if we think you have pneumonia” before stating his own opinion as “I don’t think you have pneumonia,” the physician casts the patient as a potential expert in whether he has pneumonia and gives him a slot to confirm or disconfirm. The patient agrees with the physician by shaking his head in line 44.

In the omitted lines, the physician recommends that the patient continue his treatment of his COPD as he has been, and to update his pulmonologist on his condition. In lines 46-47 the physician clarifies that he mainly wants the pulmonologist “to make the decisions obviously about the steroids” in lines 46-47. The patient then reveals one reason he may have come here rather than to the pulmonologist, saying “he’s just gonna throw antibiotics at the situation” in lines 48-49. The physician rules out the need for antibiotics, disaligning with the other physician (as characterized by the patient) and thus aligning with the patient’s implied desire for no antibiotics. The patient expresses appreciation for this (“I’m glad you said that”) and explicitly states his preference to wait (“I wanna hold out”) in lines 52-53. The physician affiliates with this preference and bids for closure with a summary “we don’t wanna use ‘em if we don’t need ‘em right?” in lines 54-55 and a “so” in line 57.

46 DOC: I mainly want him to make the decisions obviously about
47 the steroids.
48 PAT: Oh he's just- he's just gonna thro:w=u:h antibiotics
49 at the situa[tion],
50 DOC: [Okay.<.h well I don't think you need them yet.
51 (0.8)
52 PAT: Well I'm gla:d you said tha:t I wanna hold ou:t

53 and s[ee if I can't-
54 DOC: [We don't wanna use 'em if we don't need 'em
55 right?
56 (0.2)
57 DOC: So:
58 PAT: Right.
59 DOC: -> If- you know your body. If you- that's why I
60 -> [asked you.
61 PAT: [Yeah.
62 PAT: Yeah.
63 (0.2)
64 PAT: Ok[ay,
65 DOC: -> ['Cause I'm not gonna- >y'know< if you say to
66 -> me: hey ((name)) y'know I've been here befor:e
67 -> .hh then I- y'know I'll listen to that.
68 PAT: Cool.

After the patient agrees, the physician explicitly casts his reasoning for his earlier solicitations of the patient's experience with his illness and opinion about treatment with "you know your body... that's why I asked you" in lines 59-60, adding "if you say to me hey ((name)) y'know I've been here before then y'know I'll listen to that" in lines 65-67. This kind of explicit orientation to the patient as possessing his own expertise in terms of diagnosing and treating his condition is rare in the data. But in these contexts, even when there is some debate about the most appropriate course of action, it is done within the context of a legitimately shared decision. Thus, there is convergence because the physician gave the patient an opportunity to make his project explicit, and the ultimate course of action is, nominally at least, reached together.

4.4.2.4 Delivering a Serious Diagnostic Assessment

The prior extracts illustrated some of the ways there may be observable convergence in terms of project and the patient's theory of the illness. This next extract exemplifies cases where a physician delivers a potentially serious diagnostic assessment. In some cases the assessment converges with the patient's prior orientation to the problem as serious, but in others, as in this one, the physician casts the problem as *more* serious than the patient did. Although this is not technically an agreement, divergence in terms of legitimacy only appears to be problematic when there is

disagreement in the other direction (the physician treats the problem as *less* serious than the patient), and patients rarely resist potentially serious diagnoses in the data.

In this visit the patient presents a lesion on the tip of her ear that she characterizes as a “blood wart” in lines 1-2. In lines 4-5 she says she “took it upon myself” to buy some silver nitrate, a topical agent that is used to remove warts and cauterize wounds. This formulation displays some orientation to her self-treatment as one that may be typically directed by a physician. Indeed, the physician’s response, a “surprised” facial expression with raised eyebrows and rounded mouth in line 6, orients to this as unexpected and perhaps a bit extreme, which prompts the patient to quickly account for her action with “cause it was bleeding” in lines 5-7. The physician marks this as news with an “oh” in line 8. The rise in pitch on this “oh” suggests that it’s not merely a change of state registering the explanation for the silver nitrate, but rather a continuation of her “surprise” face and thus also an orientation to the bleeding as additionally unexpected. This is already beginning to suggest that the patient’s problem may be other than, and potentially more serious than, a “blood wart.” This orientation is continued with her rise in pitch and stress on “see” in “let me see” in line 15. During the exam the patient again characterizes her problem as somewhat benign when she asks “do you see that- almost looks like a little tag,” in line 21.

(13) AMH 05-12 Problem presentation through counseling

1 PAT: -> >The other thing I wanted to look at< is I did get a
2 -> blood war:t, ((touching tip of ear))
3 (0.5)
4 PAT: >on the< tip of my ear? and I: (0.2) took it upon
5 myself to buy some silver nitrate, [<() .h cause it
6 DOC [((“surprise” face))
7 PAT: was bleeding.
8 DOC: ^Oh.
9 (0.2)
10 DOC: [Yeah.
11 PAT: [profusely:.<it was just every- and it would bleed for
12 thirty minutes.
13 (1.0)
14 PAT: I- I assume because it was the tip of the ear: but
15 DOC: [^Let me see. ((moving to examine ear))
16 PAT: [.t But there’s still part- there’s still part of it
17 right ther:e,

18 (0.5)
 19 PAT: You can kind of see:,
 20 (1.5) ((DOC looking closely with magnifying glass))
 21 PAT: -> Do you see that- (>almost<) looks like [a little ta:g,
 22 DOC: [Yeah.
 23 PAT: Yeah.
 24 (1.5) ((DOC still looking through magnifying glass))
 25 DOC: °()-°
 26 PAT: [And it just (0.2) popped up over ni:ght. A:nd I'm
 27 like ^wha:t in the h(h)eck is th(h)i(h)(h)s.
 28 (1.2) ((DOC examining ear))
 29 PAT: °So: I js-°
 30 (1.5) ((DOC still examining ear))
 31 PAT: °Thought I would just ()°
 32 (2.0) ((DOC still examining ear, then backing away))

Despite the fact that “blood wart” and “tag” have overtones of candidate diagnoses, the patients adds that “it just popped up overnight, and I’m like what in the heck is this” in lines 26-27, orienting to the problem as in fact unknown, and her earlier characterizations of it as more like descriptors than true candidate diagnoses. This may be revealing her “real” concern about the problem, or her shift in orientation toward the problem as remarkable and mysterious may be in some way touched off by the physician’s own behavior treating the problem as remarkable and worthy of close examination. Indeed, throughout lines 15-32 the physician is peering closely at the patient’s ear through a magnifying glass.

After finally backing away from examining the patient’s ear, the physician delivers a diagnostic assessment “it actually looks more like a little skin cancer” in line 33. The “actually” and “looks more like” orient to disagreement between the physician’s visual impression of the problem and the patient’s prior comment that it “almost looks like a little tag.” This diagnostic assessment is observably in the direction of *more* serious than the patient treated the problem, most notably as the patient herself never expressed any particular worry about the lesion. The patient marks this as news with a higher-pitched and emphasized “really” in line 35, a newsmark that orients to the unexpectedness of this diagnosis but does not necessarily index disagreement or resistance (see Chapter 2 for analysis of this distinction). After the physician briefly elaborates “little skin cancer” as

“little basal cell” the patient accepts the diagnosis with “okay” in line 38.

33 DOC: It actually looks more like (.) a little skin cancer.
34 (0.2)
35 PAT: .h ^Really.
36 DOC: <like a little basal cell.
37 (0.2)
38 PAT: [Oka:y,
39 DOC: [So: I'm going to send you to a dermatologist to get
40 that taken care of.=`cau[se if it i:s, .hh that's kind
41 PAT: [Kay.
42 DOC: of a special area the ear: and the fac:e.
43 PAT: [Yeah.
44 DOC: [that they need to kind of >do a biopsy:< and make sure
45 if it is a skin cancer: .h do a special kind of
46 surgery? .h[h u:m but- a super common: >especially<
47 PAT: [Okay.
48 DOC: if you're- >have been in California a long time< .h
49 the tips of the ear:s (0.2) [nasolabial bri:dge under
50 PAT: [Mm hm,
51 DOC: the e:yes, is where we ge:t=
52 PAT: Mkay.=
53 DOC: those little ones.<so I'll m- I'll send you to a
54 dermatologi[st.
55 PAT: [Okay.

The physician continues to treat the problem as serious by designing her recommendation for a referral to a dermatologist as a pronouncement with “I’m going to send you to a dermatologist to get that taken care of” in lines 39-40. This design is distinct from others, e.g., suggestions, in that it asserts primary expertise and agency over the decision, and gives the patient no say in the matter (Stivers et al. 2017). The physician’s work to reassure the patient that this kind of problem is “super common especially if you’ve been in California a long time” also orients to the diagnosis as hearably serious. Throughout this, the patient continues to produce accepting “okays” in lines 41, 47, 52 and 55. The final one in line 55 is produced in last-item onset overlap, doing extra work to show acceptance and affiliation with the physician’s assessment and recommendations (Jefferson 1984d). In sum, despite the fact that the physician’s assessment of the problem differs from the patient’s initial characterization of it, because the final diagnosis is more serious than the patient supposed – indeed it’s possibly cancer, a prototypically serious diagnosis – this visit is not characterized by divergence, and visits like this rarely result in diagnosis resistance from patients in the data.

4.4.2.5 Recommending Diagnostic Tests

As alluded to throughout this section, testing sometimes plays a role in convergence, as when a physician recommends a test in a context where a patient was bidding for one; recommends a test to confirm or rule out the patient's candidate diagnosis; or treats the patient as an expert in deciding whether a test is necessary. But diagnostic testing may also play a role in cases that would otherwise be characterized by divergence. As I show in this extract, in cases where physicians deliver a likely no-problem assessment but also recommend diagnostic tests "just to make sure," patients typically do not later resist.

In this visit the patient presents with a recurring enlarged lymph node (though it is not currently enlarged), which he says seems to happen most often in the winter. During his problem presentation he says he "just wanted to have it checked out because I don't know what it is" (not shown), overtly displaying a project for diagnostic investigation and commentary. The physician does a brief history-taking about the contexts in which the patient experiences his symptoms, during which the patient volunteers that his dad had an operation on his thyroid, and "I don't know if it's anything to do with the thyroid" (not shown). In direct response to this the physician says "I'll check everything" in line 1 below, adding that she'll "check the thyroid... because of... that family history and the lymphadenopathy" in lines 1-4. She uses this mention of the technical term for an enlarged lymph node to transition into some early diagnostic commentary and recommendations. This commentary indeed preliminarily confirms the patient's characterization of his problem as an enlarged lymph node, and casts it as likely no problem, "secondary to just transient inflammation" caused by "a cold, or a virus or whatnot" in lines 4-8.

(14) AMH 04-11 Preliminary counseling

1 DOC: So we'll ch- I'll check everythi:ng, and just a note
2 I'll probably just check the th:yroid regardless,

3 because of your=tha- that family history:=an' .h the
4 lymphadenopathy,<w- we call it .hh we call it lym-
5 lymphadenopathy. .h an:d (0.2) it's (0.2) it's
6 likely jus:t (.) an enlarged lymph no:de sec- like
7 secondary to jus:t transient inflamm^ution:, could've
8 been a co::ld, or a vi:rus or whatnot? .h but we'll
9 check it we'll make sure that there's no: .hh um:
10 **problem:**, .h you u=we usually worry: if: the: lymph
11 no:de is starting to get bigger:, more than a
12 centimeter:, .h[h if it fee:ls e=u:m very hard^uened?
13 PAT: [Okay.
14 DOC: and very affixed (.) to the: to the skin? .h usually
15 if it's sma:ll (0.2) very mobile and rub^ubbery, (0.2)
16 u:m (0.2) and it goes away on its own, (0.2) that's
17 (0.2) very reassuring.<so [overall everything sounds
18 PAT: [Okay.
19 DOC: good? **but we'll go ahead and take a check? .hh u:m**
20 **and then we can talk about other b:lood tests that we**
21 **can do to make sure that there's no: sign of like**
22 **elevated white blood cell #count that's causing that**
23 **lymphadenopathy or anything like that.#**
24 PAT: Okay.
25 DOC: Okay? .t .hh u:m So let's go ahead then and go through
26 your: healthcare hi[story:~? (0.2) u:m and the:n we
27 PAT: [Yes.
28 DOC: can just get back to the main issues? and go from there.

On the heels of this no-problem preliminary diagnosis the physician presents a contrast with “but” and then states that “we’ll check it we’ll make sure that there’s no problem,” treating as legitimate the patient’s potential concern that it *is* a problem. In lines 10-17 she returns to her orientation toward the lymph node as no problem by explaining the conditions under which one *might* worry (if it’s big or hardened or affixed to the skin). Interestingly, this is the first point at which the patient acknowledges the physician’s talk with “okay” in line 13, and then again in line 18 after she contrasts these with conditions that are less worrisome, including when “it goes away on its own” in line 16, which explicitly ties to the patient’s illness experience and casts as “very reassuring” in line 17. By acknowledging and accepting the physician’s talk here but not earlier when she merely delivered a likely no-problem diagnosis, the patient orients to *this* as informative and addressing his concerns, but not that. I will discuss in further depth at the end of this section the potential benefits, in terms of mitigating patient resistance, of explaining clinical reasoning in a way that explains both what the patient’s condition is *not*, and what the physician thinks it *is*.

The physician again casts the patient's symptom presentation as "very reassuring" in line 17, adding that "overall everything sounds good" in lines 17-19. Then with another "but" she again returns to her plan to "go ahead and take a check" in 18 (referring to the physical examination), complementing her reassurance with another return to legitimizing the patient's orientation to the relevance of diagnostic investigation. She takes this a step further by adding plans for further testing with "then we can talk about other blood tests that we can do to make sure there's no sign of like elevated white blood cell count" in lines 19-23, which would indicate a more serious underlying cause of the enlarged lymph node.

Following subsequent comprehensive history-taking that is standard for new patients, the physician lists some routine blood tests, repeating as part of this list her recommendation for a white blood cell count related to the enlarged lymph node. During examination of the patient's lymph node the physician engages in extensive online explanation of what she is doing and commentary on what she is finding, including no evidence of currently enlarged lymph nodes or an enlarged thyroid (not shown). Following this, she again reviews her plan for testing and follow-up visits, including the test of the patient's white blood cell count.

In sum, although the physician has oriented to the patient's problem as likely *no* problem, she has interspersed her reassurance with comments underscoring the legitimacy of the patient's orientation to the problem as potentially worrisome. Her recommendation for a diagnostic test is part of this and may go further in making the patient feel that his concerns are being addressed. Notably, in this case and cases like it, the physician frames the test as medically indicated due diligence. This contrasts with other cases where physicians may recommend tests in the context of no-problem or no-findings assessments but then suggest that they don't expect to find anything, which typically lead to resistance.

4.4.2.6 Patients Letting Physicians “Off the Hook”

In a few cases, no-problem diagnoses which might otherwise observably diverge from the patient’s tacit orientation to their problem as doctorable and lead to resistance are not observably divergent, because the patient has done work to orient to a no-problem diagnosis as acceptable or even desirable. Consider Extract 15.

In this visit the patient presented with shoulder stiffness and immobility after reaching for something in her closet. During physical examination the physician asks if the patient has “had problems with that shoulder before” in lines 1-2. The patient responds “just the arthritis” in line 3, which the physician takes up with a repeat (“just the arthritis,”) and acknowledgment token “yeah” in line 4. Although this brings up a possible cause of pain and immobility in the arm, it is delivered as minimal (“just”) and known (via the determiner “the”), and thus as neither a concern nor a candidate diagnosis for the patient’s problem. The patient then answers “more than the question” (Stivers & Heritage 2001), expanding her answer with “but it just scared me when I couldn’t move it like for a few min(utes)” in lines 5-7.

(15) AMH 03-05 History-taking into diagnostic assessment

1 DOC: Have you had problems with that shoulder
2 before?or
3 PAT: Just the arthritis.[=someti-
4 DOC: [Just the arthriti[s,[Yeah.
5 PAT: -> [Ye[s. But
6 -> I- it just scared me when ih- I couldn't mo:ve it
7 -> l[ike for a few min-
8 DOC: [Just for: a few minut- Ok[ay.
9 PAT: [Yeah.
10 **DOC: Yea:h no that's fine.Yeah [it's probably just**
11 PAT: [(so) I jus:::
12 **DOC: the- the position that you were in.**
13 PAT: Yeah.
14 **DOC: Or something you di[d to aggravate it.**
15 PAT: [Maybe just twist it.=I [know
16 DOC: [Yeah
17 PAT: I said I [gotta ask when I come in.
18 DOC: [Yeah.
19 DOC: O:h heh .h I'm just gonna press on your sinuses

This comment explicitly shows a desire for reassurance rather than a diagnosis *per se*. Coming on the heels of history-taking and physical examination of the problem, it in some way works to take the pressure off the physician to extensively work up this problem beyond a rule-out of something more serious. The physician immediately aligns with this, abandoning his line of inquiry, collaboratively completing the patient's turn with "just for a few minut(es)" (line 8), and delivering a diagnostic assessment of "yeah no that's fine...it's probably just the position you were in... or something you did to aggravate it" in lines 10-14. This diagnosis is designedly no-problem in a number of ways. First, "that's fine" explicitly casts the problem as indeed no problem, ruling out not a specific concern, but rather *anything* that might be concerning about the patient's symptoms. Then, when the physician adds a comment about what the problem might actually be, the assessment he delivers is not so much a diagnosis as a vague etiological description that is minimized ("just"), uncertain ("probably"), and imprecise ("the position that you were in"; "something you did to aggravate it"). These all treat actual diagnosis as unnecessary and further underscores the non-seriousness of the patient's symptoms.

But unlike other cases where a physician delivers such an overtly no-problem diagnosis, this is delivered and received unproblematically, and indeed rather than pushing back against this threat to the legitimacy of her problem the patient affiliates through an acknowledgment token ("yeah" in line 13) and collaborative completion ("maybe just twist it" in line 15) before the physician moves on to physical examination for a separate problem in lines 19-20. This diagnosis does threaten the legitimacy of the patient's decision to bring up this problem, which permeates the patient's behavior (e.g., "so I jus..." in line 11 and "yeah I said I gotta ask when I come in" in lines 16-17). Indeed, the patient's focal move in this extract ("it just scared me when I couldn't move it..." in lines 5-7) itself does work to cast the patient as troubles-resistant and reasonable (Heritage & Robinson 2006a).

Nonetheless, this diagnostic assessment is not *diverging* from the patient's because of the obvious work she does to project that reassurance is acceptable and that a more precise or "problem" diagnosis is unnecessary.

4.4.2.7 Explaining Clinical Reasoning

As the prior extracts in this section illustrated, patient resistance appears to be primarily mitigated by the physician giving the patient what they want – either because the clinical picture happens to converge with the patient's assessment, or perhaps in some cases because the physician gives in to patient pressure, which physicians have indeed been found to do (Stivers et al. 2003; Stivers 2007; Heritage et al. 2010; Whiting et al. 2007). In other cases, patients let physicians "off the hook" in terms of assessing their problem beyond rule-outs or reassurance. These scenarios are at best outside the physician's control, and at worst not clinically sound. There are, however, a small set of cases where there *is* observable divergence but no later resistance; in these cases, physicians have done work to bridge the resulting gap by explaining their clinical reasoning in a way that ties to the patient's concerns.

Explaining clinical reasoning is different from explaining a diagnosis itself or merely accounting for its evidential basis, both of which can be seen in the examples of divergence and resistance illustrated in Part 1 of this chapter. Explaining a diagnosis involves describing the nature of a diagnosed condition, its etiology, physiological mechanisms, etc. We saw this in Extract 1, where the physician explained plantar fasciitis as a fibrous band that attaches to the heel bone and stiffens and tightens with age. When physicians explain diagnoses, they work to help the patient understand what's wrong with them and why they're experiencing the symptoms they are. They do not, however, explain to the patient the clinical reasoning underlying the divergence between the patient's assessment and the physician's.

Physicians also account for the evidential basis of a diagnosis, especially in cases of divergence. Accounting practices include commenting on the evidence as it unfolds during the physical examination via online commentary (e.g., in Extract 3, “this ear looks good”; Heritage & Stivers 1999); incorporating into a diagnostic utterance a reference to the evidence upon which it’s based via an evidential verb but without singling out a specific observation (e.g., “it *looks like* X”); explicating the evidence, i.e., asserting specific observations that support a particular diagnosis or rule-out (e.g., in Extract 5, “the lungs sound great, you’re moving air really well”); and making evidence directly observable, e.g., by showing the results of an x-ray (Peräkylä 1998). Although these accounts display for the patient the evidential grounds of a diagnostic assessment, as Peräkylä (1998:308) writes, “the fact that the grounds of a diagnosis are observable and intelligible does not mean that the patient perceives, interprets, or uses the evidence in the same fashion as the doctor.” Evidential accounts are preoccupied with persuading a patient that an assessment is the right one through *justifying* it, but not actually explaining the physician’s clinical reasoning.

In contrast, explaining clinical reasoning often constitutes a separate activity focused on bridging the gap between the patient’s understanding of the problem and the physician’s assessment. Physicians may do this, as in the following extracts, by explaining what they were doing or what they were looking for during the physical examination, and then explaining how what they found was evidence for (or against) a particular diagnostic assessment. In other cases, physicians may explain the reasoning process more generally, e.g., in Extract 14, where the physician explained the conditions under which a physician might worry about an enlarged lymph node, and the conditions under which they would not, which incorporated the patient’s own symptoms. Although it’s rare in the data, physicians may also explain the clinical reasoning underlying a particular course of action, e.g., recommending against a particular diagnostic test. In the cases under consideration, physicians explain not only how to see what the problem *is*, but also what it *is not*, focusing on the patient’s

concerns in particular.

Of course, even through this work physicians are not *actually* getting patients to perceive, interpret or use evidence as they would. But they are moving to observably bridge that gap, showing that they have considered the patient's point of view and providing the patient with some understanding of how and why the clinical picture differs from it. Consider the next two extracts.

In the first extract, the physician's diagnostic assessment disagrees with the patient's candidate diagnosis. In this visit the patient presented with shoulder pain, which he described as associated with an old "rotator cuff injury" (not shown). In lines 1-2 the physician diagnoses the problem as an injury to the patient's labrum, a separate part of the shoulder: "I actually am suspicious that there could be an injury to the labrum." This diagnosis is epistemically downgraded with "suspicious" (which also works to foreshadow further diagnostic testing) and "could be." By adding "actually," the physician also displays an understanding that this diagnosis may be unexpected for the patient (Heath 1992; Clift 2001).

(16) AMH 01-06 Diagnosis into counseling

1 DOC: Oka:y >well< I actually am: suspicious that there
2 could be: an injury to:: the labrum.
3 (1.0) ((DOC typing))
4 DOC: of the shoulder.
5 PAT: Okay?
6 (2.0) ((DOC typing))
7 DOC: I- I might actually have a labrum injury
8 myself.
9 (2.0)
10 DOC: U:m:
11 PAT: You have my sympathy,
12 DOC: Ah ha ha ha ha .hh so:: (0.8) the labrum i:s
13 basically: (0.5) um: (.) thee uh: pocket (0.5)
14 um: tha:t uh (0.5) u:h connects=that (.) kind of
15 hol:ds the joint together?
16 (0.5) ((PAT nods))
17 DOC: u:m (.) so: (.) if you look- (0.5) ((turning
18 **computer to face PAT**)) so- (0.5) I- I was testing
19 **your rotator cuff mu[scles, your bicep is one**
20 PAT: [Mm hm,
21 **DOC: of your rotator cuff tendons, .h your bicep tendon**
22 **is not tender, .h I tested your supraspinatus**
23 **tendo[n?**
24 PAT: [Mm hm,

25 (0.2)
 26 DOC: **And that was not tender, .h u:m**
 27 DOC: **But- when:- when you're having troubl:e uh-**
 28 **sleeping on that shou^lder? (0.2) .h it is**
 29 **suggestive o:f a: labrum (.) tear.**
 30 PAT: Mm [hm,
 31 DOC: [injury.

After a full second of silence in line 3, the physician pursues response with an increment “of the shoulder” in line 4. The patient accepts with “okay” in line 5, but bids for physician expansion with rising intonation. The physician continues typing, and then commiserates with “I might actually have a labrum injury myself” in lines 7-8. The patient responds with “you have my sympathy” in line 11, which may in fact foreshadow or even indicate acceptance of the diagnosis, as he affiliates with the physician’s commiseration. But the physician goes on to explain the diagnosis, and some of his clinical reasoning underlying it.

The physician first explains what the labrum is – “basically the pocket that kind of holds the joint together” in lines 12-15. He then explains the clinical reasoning underlying the divergence of his assessment from the patient’s. He starts with “I was testing your rotator cuff muscles, your bicep is one of your rotator cuff tendons, your bicep tendon is not tender” in lines 18-22. This explains the reasoning behind part of the physical examination, displays for the patient that the physician did indeed investigate the patient’s theory of the illness, and presents the evidence gleaned from the exam that rules out the patient’s concern. The physician then adds that the supraspinatus tendon is not tender in lines 22-26, which is hearably the second in his list of rotator cuff tendons and provides further evidence that the rotator cuff is not the problem. Then in lines 27-29 the physician adds that “when you’re having trouble sleeping on that shoulder? it is suggestive of a labrum tear” in lines 27-29. This now accounts for evidence *for* the physician’s suggested alternative diagnosis. Extract 17 shows another instance of a physician working to explain the clinical reasoning underlying his divergent assessment.

In this case the physician’s diagnostic assessment actually agrees with a candidate diagnosis

the patient proposes, but it diverges from a more subtle aspect of how she shows she understands the nature of the problem. It is this to which the physician attends as he explains the basis of his divergent assessment.

In this visit the physician solicits the problem with a candidate “your ear?” in line 1. The patient confirms with “yeah” in line 2 and then elaborates that “it’s been clogged up ever since Friday” in lines 2-3. In line 10 the physician asks if her ear hurts or itches, in response to which she backs up in time for a small telling about how “Friday it was painful” (line 11), “but now I get a little bit of sharp pains a little bit?” (lines 13-14). By repeating “a little bit” the patient downplays the severity of the pain. The physician takes this up and pursues elaboration with a rising-intoned “mm hm” in line 15, and the patient adds an increment to her answer with “not all the time though,” displaying that the pain is not central to her concern about her ear.

On the heels of this increment the patient rushes through to another unit of talk where she adds “but it’s like, it feels like something’s stuck in there” in lines 16-17. The framing of this as a contrast to what she cast as non-concerning pain portrays this symptom – the feeling that something’s “stuck in there” – as the thing she *is* concerned about. The physician does not take this up, instead moving to a new line of inquiry with “how ‘bout your throat” in lines 18-19.

(1a) PCT 41-02 Problem presentation into history-taking

1 DOC: I hear that your ear?
2 PAT: -> Yea:::h. (0.2) It’s been clogged up ever since
3 -> Friday.
4 DOC: Did you use any um (0.5) Q-tips to the ear.
5 PAT: U:m:: N:o.
6 (0.2)
7 PAT: I did toda:y, just (.) around (.) in the- outside
8 not in the [inside though.
9 DOC: [Mm hm,
10 DOC: So does it hur:t, does it i:tch,
11 PAT: Frida:y it was painf[ul.
12 DOC: [Oka[:y,
13 PAT: [Bu:t (0.2) now:: (0.2) I
14 get a little bit of sharp pains a little bit?
15 DOC: Mm hm,
16 PAT: -> Not all the time though.=But it’s (.) like (.) it
17 -> feels like (0.2) something’s stuck in the[r:e.

18 DOC: [How 'bout
 19 your throat.
 20 PAT: No.
 21 (0.8)
 22 DOC: Okay.

During the physical exam, after looking in the patient's ears, the physician asks "have you had an ear infection in the past" in line 1 below. This question reveals his clinical reasoning-so-far, not going so far as to convey that this *is* an ear infection, but at least suggesting that an infection has entered his line of inquiry. In response the patient says, "oh yeah" with stress on the "oh," followed by a laugh particle in line 2. As a change-of-state token in response to a question, this turn-initial "oh" marks the question as inapposite or unexpected (Heritage 1998) and casts its confirmation as somehow obvious or to be expected. The laugh particle following this answer marks it as potentially troubles resistant (Jefferson 1984a), which only further underscores the commentary it made on the inappropriateness of the physician's question. By answering the question in this way, the patient suggests familiarity with ear infections, perhaps through a long or severe history of them, and implies an underlying expectation that this *is* an ear infection.

The physician listens to the patient's lungs in lines 3-7, and then closes the physical exam with two "goods" and a transition-relevant "alright" and "so look" in line 9. He then launches an expanded diagnosis of an ear infection, during which he explains the diagnosis as well as some of his clinical reasoning underlying it. He opens by holding up a diagram of the auditory system, topicalizing the examination ("we were looking at the ears already" in lines 10-11) with reference to the diagram ("if you look at the ears... here's your ear drum" in lines 9-12.

(1b) PCT 41-02 Physical examination

1 DOC: Have you had an ear infection in the past,
 2 PAT: -> Oh yeah. \$hhehh\$
 3 DOC: Okay. So: lemme have you take a few deep breaths.
 4 (0.5)
 5 DOC: In and out.
 6 (0.8)
 7 DOC: One more,
 8 (0.8)

9 DOC: Good. Good. Alright so look the ear drum. (1.5) If
 10 you look at the ears. (.) (We were) looking at the
 11 ears alrea:dy. Here. ((showing diagram)) (2.0) Okay
 12 here's your ear drum. right here.
 13 PAT: Mm hm?
 14 (0.5)

The physician then explains that the patient's ear canal and ear drum are both red, in lines 15-16 and 18-19. By explicating this evidence while holding up the diagram, the physician works to explain his clinical reasoning, which he explicitly ties to his diagnosis with "that means it's infected" in line 19.

The physician then moves on to an explanation of the mechanism of the diagnosis, still holding up the diagram, to explain why it might feel like the ear is blocked. He explains that the ear drum is "not moving" (line 19) and that "the air goes in there, but this guy the ear drum doesn't move ... that's why you can't hear very well out of it" (lines 22-26).

15 DOC: Okay so the: ear (0.8) canal.=the: ear canal is a
 16 little red,
 17 PAT: Mm hm,
 18 DOC: And the ear (.) drum (0.2) right there? (0.2) looks
 19 re:d.=So that means it's infe:cted.=So it's not moving
 20 ((gestures mimicking ear drum vibration))
 21 PAT: Oh.
 22 DOC: So thee: as I'm- talking to you (0.5) the air (0.5) goes
 23 in there, but this guy the ear drum doesn't move.
 24 (0.5)
 25 DOC: as well so that's why you- you can't hear very well out
 26 of it.=It feels like it's plugged.
 27 (0.8)
 28 DOC: Well, its no:t plugged.=There's no wax in there.
 29 (0.5)
 30 DOC: But the ear drum is- (0.2) it's in- inf- it's infected
 31 that (0.5) it doesn't move as well.
 ((moves on to Rx))

In line 26 the physician rushes through from "that's why you can't hear very well out of it" to add "it feels like it's plugged." This ties directly back to the patient's own earlier comments that her ear is "clogged up" and "it feels like something's stuck in there." He explains that "it's not plugged," adding evidence again from the physical exam that "there's no wax in there" in line 28. As in the previous extract, this explanation explicitly works to bridge the gap between the diagnosis and

the patient's prior description of her illness experience – that it feels like something is stuck in her ear – by explaining the clinical reasoning underlying the divergent assessment and attending along the way to the patient's own concerns.

In both of these cases, the physicians' assessments diverge from the patients' in similar ways to cases where one might see a physician merely *accounting* for the evidential basis of their divergent assessment. Indeed, these physicians *are* doing that. But they're doing more than merely referring to or asserting the evidence in passing while delivering the assessment, as a sort of perfunctory nod at accounting for their clinical decision-making. Accounts like that persuade through justification, casting the situation as one of disagreement, the patient as skeptical, and the physician as defensive. In contrast, explanations like this, where the physician engages in an activity observably dedicated to helping the patient understand the grounds of the divergence between their assessment and the physician's, persuade through understanding. They cast the patient as someone who *can* and *wants* to understand, they treat the patient's original concerns as legitimate, and they orient to persuasion not as a challenge to authority, but as a legitimate step in addressing patient concerns.

4.5 DISCUSSION

As discussed in Chapter 1 and at the outset of this chapter, primary care is a unique clinical context where physicians see patients drawn from the general population, who present with a wide range of often overlapping and undifferentiated symptoms (Summerton 2000). Establishing a diagnosis may not always be possible, nor desirable from the clinical perspective. In this context, a physician's main concern is to identify patients whose symptoms indicate serious illness for diagnostic testing or referral (Heneghan et al. 2009). For those whose symptoms are not serious, which represents the bulk of patients, a primary care physician's job may be to merely reassure them

that there is seriously nothing wrong, initiate symptomatic treatment, and otherwise act as a gatekeeper to diagnostic tests, referrals to specialized care, and treatment (Scott 1977; Green & Holden 2003). Patients, however, may expect more than this, especially in a historical context where they are more informed, empowered and engaged than ever (Timmermans 2020), are taking a more consumerist approach to healthcare (Timmermans & Oh 2010), and are approaching their relationship with physicians as something more akin to a client-provider relationship than an authoritarian one (Reeder 1972; Stivers & Timmermans 2020).

This is a context ripe for discord between what patients think or want, and what physicians are willing or able to concede. Indeed, in the context of treatment, patients have been shown to actively push for certain treatment outcomes, and to resist – or even initiate treatment negotiations – when the physician recommends something else (e.g., Stivers & Timmermans 2020). As I have shown in this dissertation, even in the context of diagnostic assessments, considered the “fulcrum in the exercise of medical authority” (Heritage 2005b), patients are engaging in resistance in primary care far more often than previously supposed. Diagnosis resistance presents social and interactional challenges for both physicians and patients, where physicians are having their normative role in addressing patients’ health problems undermined, and patients are struggling to get their concerns addressed. The question I asked in this chapter was: what are the interactional processes leading patients to resist physicians’ diagnostic assessments, both in individual visits and across primary care visits more generally?

To answer this question, I used conversation analysis to examine the wider interactional context of acute care visits to identify commonalities among cases where resistance occurs, and contrast these with cases where it does not. My central finding is that diagnosis resistance occurs in cases where there is observable *divergence* between patients’ and physicians’ assessment of the patient’s problem, which typically occurs along the lines of departure from a patient’s expectations,

e.g., for a particular test, referral, or treatment; disagreement with a patient's diagnostic hypothesis or broader theory of the illness; or challenges to the doctorability of the patient's problem.

In Part 1 of my analysis, I illustrated a variety of ways such divergence emerges, and how it observably leads to diagnosis resistance. All of the cases I showed exhibited the same parts of a divergence-resistance trajectory: a patient does work early on to cast their problem in a certain way; a physician's subsequent line of inquiry and assessment diverge from the patient's own assessment of the problem; and the patient's subsequent resistance is observably tied to how they initially discussed their problem. Cases varied in terms of the lines along which divergence emerged; the explicitness of the patient's work to convey some aspect(s) of their assessment of the nature of their problem; the intensity and directness of the emerging divergence; and the degree to which the patient's subsequent resistance explicitly renewed or even revealed more about the patient's original concerns. But what these cases share in common, as I argue all cases of resistance preceded by divergence share, is that a through-line *is* observable from divergence to resistance, such that the patient's resistance observably emerges out of the gap between the patient's concerns and how the physician is addressing them during counseling.

This concept of divergence fits with my broader conceptualization of diagnosis resistance. As a physician moves from the problem presentation through history-taking, physical examination and assessment, the physician's assessment apparently begins to diverge (or not) from the patient's own assessment. During information-gathering, the physician's assessment is normatively under development as the visit progresses, and any divergence from the patient's assessment unfolds across time. If divergence becomes apparent early, a patient may do work during information-gathering to shape the physician's assessment, perhaps to pull it back towards their own concerns. But once the physician transitions across a moment of assessment and into counseling, whatever gap is there is solidified, as this is a normative activity context where the physician's assessment is no

longer being shaped. What lies within that gap are unaddressed patient concerns. As the visit moves toward closing, a patient may see that their concerns will remain unaddressed absent some intervention to reopen assessment activities. This is exactly what diagnosis resistance does.

In Part 2 of my analysis, I contrasted cases of divergence and resistance with cases where patients ultimately do not resist, examining differences in how they unfold that could further explain the interactional processes leading to resistance more broadly. I showed that these cases typically involve convergence between patients' and physicians' assessments of the patient's problem, e.g., the patient's diagnostic theory is confirmed or they are given some treatment, test, or referral they were seeking; the physician treats the patient as an expert on their condition; the physician delivers a diagnostic assessment that is as serious as, or more serious than, the patient oriented to the problem; the physician recommends diagnostic testing, framing this testing as clinically legitimate; or the physician delivers an indeterminate or no-problem diagnosis after the patient does some work to let them "off the hook" in terms of diagnosing the problem.

The problem with these findings is that they suggest patient resistance can only really be mitigated under certain conditions, where the clinical picture happens to converge with the patient's expectations or theories (or the physician gives in to patient expectations regardless of clinical indication), or the patient happens to let the physician off the hook. However, I also illustrated cases where there *is* observable divergence but no later resistance; in these cases, physicians have done work to explain the clinical reasoning underlying their divergent assessment in a way that ties to the patient's concerns. This practice may mitigate patient resistance because it bridges the gap between the patient's concerns and the physician's assessment by providing evidence that the physician *has* considered the patient's point of view, casting the patient as someone who *can* and *wants* to understand the difference between how they conceived of the problem and how the physician has assessed it, and orienting to persuasion not as a challenge to authority, but as a legitimate step in

addressing patient concerns.

The first implication of the findings in this chapter is that, in cases where a physician's assessment *is* divergent from a patient's – which is in fact a frequent occurrence in primary care – physicians may be able to mitigate resistance by explaining that divergence in a way that makes an observable effort to explain the clinical reasoning underlying that divergence, including not only the reasoning for what the problem *is* but also what it is *not*. Of course, a physician could not possibly enumerate all aspects of the clinical reasoning they engage in over the course of a single visit, nor should they. But what may be helpful for patients is to be shown, from the medical perspective, the difference between how *they* saw the problem, and how the physician has assessed it.

Unfortunately, patients rarely explicitly communicate their underlying concerns or assessment of their problem in the beginning of visits. As can be seen in the extracts in this chapter, patient signs are often implicit; in some cases, patients reveal later in a visit that what they hinted at in the beginning wasn't their “real” concern; sometimes patients send mixed signals; and sometimes they don't indicate in any way how they view their problem or what their concerns are, and it doesn't become clear that they *had* a particular concern until they reopen information-gathering toward the end of the visit. More often than not, it seems, patients defer to the physician to determine how to relevantly address their problem, sometimes sending “trial balloons” by hinting at their underlying concerns, and sometimes not. Then they resist when the physician didn't address the problem in a way that aligns with or addresses their concerns.

Indeed, many studies have found that patient expectations are often not only unmet but unvoiced by patients (e.g., Barry et al. 2000; Bell et al. 2001), and that the most commonly unvoiced agendas include worries about specific diagnoses and what the future holds, ideas about what is wrong, and information relating to the social context. Bell and colleagues (2001) report that patients who have at least one unvoiced expectation are less educated, younger, and more distrustful of

physicians in general. This finding suggests that patients are more likely to keep their “true” concerns concealed when the perceived gap between physician and patient expertise is greatest, or when they are less convinced that a physician cares to know their perspective. As discussed earlier, patients may more generally not reveal their underlying concerns due to a lingering orientation to a legacy of epistemic and interactional asymmetries between physician-as-expert and patient-as-layperson. But another part of the problem is that physicians aren’t asking them.

Before the 19th century, physicians’ only real source of insight into the nature of a patient’s problem was the patient’s story itself, as few physical examination techniques and diagnostic technologies had yet been developed (Shorter 1985; Iida & Nishigori 2016). But as the medical profession began to shift its focus to pathological anatomy and new diagnostic techniques were developed throughout the 19th century, patients’ bodies began to be seen as analyzable objects in their own right (Foucault 1976 [1963]), and patient stories began to take a back seat (Shorter 1985). Medicine developed a primarily biomedical, disease-oriented focus, which contrasted with a more lifeworld, illness-oriented focus; this orientation persisted through the “golden age” of doctoring, when the dominance of the medical profession in society was at its height (Freidson 1970a,b; McKinlay & Marceau 2002). However, beginning in the mid- to late-twentieth century, a patient-centered care movement began to emerge, which has since become widely viewed as an ideal way for physicians to communicate with patients, and which again places a focus on discovery of the patient perspective, as well as shared control (Illingworth 2010). Although patient-centered care is often criticized for lacking precise definitions and an evidence base, there are some specific bits of advice for physicians when it comes to discovering the patient’s perspective, including mnemonics like “FIFE,” which stands for: patient’s *f*eelings about their problem, *i*deas about what is wrong, effect of illness on *f*unctionality, and *e*xpectations from the doctor (Stewart et al. 1995; cited in Illingworth 2010).

However, physicians are in general neither pursuing these aspects of the patient's perspective, nor legitimizing or addressing them in contexts of divergence. This may be due to the profession's continued focus on the biomedical perspective (Mishler 1984), most strongly expressed through evidenced-based medicine (EBM). According to Bensing (2000), there is a gap between what is recommended in terms of patient-centered care, and what is practiced in terms of EBM, which is disease-oriented rather than patient-oriented. Although EBM indeed helps protect patients by ensuring consistently distributed, high-quality care, as Bensing (2000) writes, "the uniqueness of patients, their individual needs and preferences, and their emotional status are easily neglected as relevant factors in decision-making." This is particularly a problem in primary care, where diagnostic uncertainty is high, there is a relatively low prevalence of serious disease, treatment is often low-tech, and physicians and patients are meant to sustain long-term relationships (Slowther, Ford and Schofield 2004).

Yet primary care physicians appear to be maintaining an EBM-oriented approach, which may partly have to do with the healthcare organization within which they work, its incentive structure for specific types of outcomes, and its requirements of physicians in terms of documenting and reporting their process of medical care. Indeed, Solomon and colleagues (2012) have found that both physicians *and* patients perceive patient-centered approaches as at odds with external factors like clinical guidelines, outcome measures, and pay-for-performance targets, as well as limits on the time patients have to talk with their physicians. Even physicians who want to practice patient-centered care may face a dilemma between following clinical guidelines and being guided by patient preferences, as most guidelines are driven by an EBM approach, and few guidelines reconcile the two approaches (Krahn & Naglie 2008).

It is for these reasons, and perhaps more, that physicians are neither pursuing patient concerns nor working to legitimize or address them when their clinical assessment or course of

action is divergent from the patient's perspective. Yet it is likely precisely because of this prioritization of the biomedical approach – enacted and sustained by both physician and patient focus on symptoms and signs of illness rather than the patient's lifeworld perspective (Mishler 1984; Mishler et al. 1989; Clark & Mishler 1992) – that patient concerns are not being met, and that diagnosis resistance is so prevalent.

Taken together, the findings from this chapter underscore the recommendation from patient-centered care scholars that physicians should actively pursue the patient's perspective, either by directly asking the patient, or providing the patient with opportunities to expand something they've already said. This would help physicians address those concerns later, especially in contexts where their assessment is divergent from how the patient sees their problem. Importantly, studies have shown that pursuing the patient's perspective indeed improves resolution of patient concerns without lengthening visits (Henbest & Fehrson 1992; Levinson, Gorawara & Lamb 2000; Mauksch et al. 2008). This makes sense, given that diagnosis resistance in contexts of divergence and unaddressed concerns likely lengthens visits.

More research is needed to investigate the best ways physicians can pursue the patient perspective in acute primary care visits, how they can best use this information to address patient concerns in cases of divergence, and the effects of these behaviors on outcomes like patient resistance, visit length, and physician and patient satisfaction at the end of the visit. The findings from this chapter provide empirical underpinnings, based in a grounded look at what's going *wrong* in primary care, to support the ongoing appeals for physicians to indeed pursue and address the non-biomedical aspects of patient concerns, especially in primary care.

CHAPTER 5:

Conclusions

5.1 SUMMARY OF FINDINGS

In this dissertation I examined how patients resist primary care physicians' diagnostic assessments, how physicians respond, and the interactional processes leading up to resistance. In this conclusion chapter, after briefly summarizing the main findings from each analytical chapter, I consider the implications these findings have for the fields of conversation analysis, doctor-patient communication and medical sociology, focusing particularly on what physicians' and patients' behaviors in contexts of diagnosis resistance can tell us about the status of medical authority in US primary care, and what it means for patients' experiences of healthcare delivery.

5.1.1 Chapter 2

In Chapter 2 I operationalized diagnosis resistance as *any patient action which, at any point during counseling, not only stalls but initiates reversal of the visit's progressivity, renewing the relevance of diagnostic inquiry by making a move to an activity context where the physician's assessment may still be shaped*. Although actions thus defined as resistant enact a reluctance to accept or go along with a diagnostic assessment, they do *not* necessarily index disagreement or rejection of that assessment. Nonetheless, by in some way inviting reconsideration of the fit between the physician's assessment and the patient's experience after the shift to counseling, diagnosis resistance presents an implicit challenge to physicians' medical authority and risks undermining the nature and purpose of the visit.

This operationalization identifies resistance through a kind of objective hermeneutics turning on the structural organization of acute care visits and the position diagnostic assessment occupies in that organization. It captures a range of actions beyond overt challenges and brings into focus the

interactional resource patients are ultimately drawing on to interrupt the progressivity of a visit in service of whatever lingering concerns they may have about how their problem is being assessed, absent the possibility of passive resistance. I found three main types of resistant actions in the data: those which substantively fall in the domain of clinical knowledge and are formatted as questions, which most overtly challenge local epistemic and interactional asymmetries; those which substantively fall in the lifeworld domain and are formatted as assertions, which present the least overt challenge; and those which I argue cross domains by framing something substantively in one domain, e.g., a symptom description, in the format of the other domain, e.g., a question. These last actions fall in the middle in terms of how overtly they challenge the physician's epistemic authority and progressivity toward visit closing.

I found that patients are resisting diagnostic assessments far more often than previously supposed, as much as 80 percent of the time. However, I also found that patients tend to resist in the least overt ways, relying primarily on actions which substantively fall in their own domain of lifeworld expertise and which interactionally place the least constraints on physicians to respond. Patients also do extensive work to mitigate the inappositeness of their resistant turns and the challenge they may present to the physician's authority. These findings suggest that patients are orienting to their resistance as potentially problematic, even if the purpose of that resistance was not to disagree with the physician's assessment or challenge their authority *per se*.

5.1.2 Chapter 3

In Chapter 3 I examined how physicians respond to diagnosis resistance, which presents a challenge to their interactional authority to have moved into counseling and their epistemic authority to have assessed the problem in the first place; creates a response slot where reconsideration of the patient's problem, reassertion of the original assessment, and/ or pursuit of the patient's underlying

concerns is at least potentially relevant before resuming counseling activities; and presents a kind of interactional roadblock to closing in a context where physicians have limited time to spend with each patient.

I found three categories of physician response in the data: brush-offs, physician-centered responses and patient-centered responses. With brush-off responses patient actions are interactionally bypassed without being treated *as* resistance. These actions typically afford the fastest return to the physician's interactional agenda. In contrast, physician- and patient-centered responses do treat a patient's actions as resistant, either by pushing back against it or to varying degrees aligning with the patient's invitation to return to information-gathering and/or reassessment. With physician-centered responses physicians work to move past the resistance and return to their clinical agenda as quickly as possible, while with patient-centered responses they work more expansively to acknowledge or address patient concerns before moving on.

I found that physicians tend to prioritize maintaining progressivity and their own agenda over responses that attend to or otherwise pursue patient concerns, which may in part be driven by institutional constraints on their time. But this trend is also shaped by how patients resist in the first place, with physicians more likely to brush off the least overt types of resistance, which are themselves the most common. There is almost a sense of collusion between patients and physicians to keep diagnosis resistance off-record and to protect the progressivity of the visit from being too compromised by it. However, I also found that patients are in general more likely to pursue response to their resistance than to abandon it, and that this trend is strongest following brush-off responses. This suggests that whatever lingering patient concerns are driving diagnosis resistance, they are still not being addressed.

5.1.3 Chapter 4

In Chapter 4 I explored the interactional processes leading patients to resist physicians' diagnostic assessments, both in individual visits and across primary care visits more generally. Examining what happens in the lead-up to resistance, I identified commonalities among cases where resistance occurs, and contrasted those with cases where it does not. I found that diagnosis resistance occurs in cases of observable *divergence* between patients' and physicians' assessment of the patient's problem. Once counseling begins and the physician's assessment is no longer ostensibly under development, divergence solidifies into a gap between patient concerns and how the physician is addressing them, which persists through visit closing absent some move to reopen assessment activities. I argue that diagnosis resistance emerges out of this gap.

In contrast, I found that visits where patients do not resist are characterized by *convergence* between patients' and physicians' assessment of the patient's problem. This suggests that patient resistance can only be mitigated when patients get what they want, or their theories are confirmed. However, I also examined a small subset of cases where there *is* observable divergence but no later resistance. In these cases, physicians have done work to bridge the resulting gap by explaining their clinical reasoning in a way that ties to the patient's theory or concerns. This may point to one way physicians can mitigate resistance even in contexts of divergence. Unfortunately, patients rarely explicitly communicate their underlying concerns or assessment of their problem, and physicians rarely pursue them.

Taken together, the findings from this chapter underscore recommendations from patient-centered care scholars that physicians should actively pursue not only the biomedical aspect of a problem, but also the patient's perspective, including their expectations, feelings, theories, and concerns about that problem. Such recommendations still remain more of an aspiration than a clinical reality, but this would help physicians address those concerns later, especially in contexts

where their assessment is divergent from how the patient sees their problem. This could potentially mitigate the effects of divergence, reduce the overall rates of diagnosis resistance in primary care, and improve patients' experiences with their healthcare.

5.2 IMPLICATIONS OF FINDINGS

5.2.1 Implications for Conversation Analysis in Medical Settings

The findings of this dissertation contribute to the field of conversation analysis by operationalizing, specifying and expanding what we know about diagnosis resistance in medical encounters. Whereas prior conversation analytic studies of diagnosis resistance (Heath 1992; Peräkylä 1998, 2002, 2006; Stivers 2007; Ijäs-Kallio et al. 2010) focused on specific and sometimes disparate actions that hearably challenge a diagnosis, the operationalization of diagnosis resistance I put forth in Chapter 2 turns on the structural organization of acute care visits and the position diagnostic assessment occupies in that organization. It attends to what other conversation analysts have characterized as diagnosis resistance, but goes beyond what those studies have found in two key ways: it focuses on resistance to *diagnostic assessments* rather than diagnoses *per se*; and it examines resistance beyond the turn(s) immediately following a diagnosis for resistance, looking instead at the entirety of the counseling activities, beginning at the shift from information-gathering and ending at visit closing. This operationalization is intended to more closely reflect how assessment actually works in primary care, and the multifaceted ways patients push back. It is also generative, enabling other conversation analytic scholars to identify instances of resistance even if what they see in their data does not look like what has been illustrated in this dissertation. This is an operationalization that future studies can use and build on.

One major implication of my proposed operationalization of diagnosis resistance is that it reveals far more resistance than previously supposed. Whereas previous studies suggested that

patient resistance to diagnosis is rare, this operationalization reveals that it may happen as often as 4 out of every 5 primary care visits for new or acute problem. This fundamentally shifts our ideas of whether and to what extent there are interactional problems related to diagnostic assessment in primary care, and points to a need for further investigation.

In the process of establishing my operationalization I made a distinction between actions which can be said to merely stall progressivity toward visit closing, and those which project *reversal* of the visit's progressivity, renewing the relevance of information-gathering and returning to an activity context where the physician's assessment may still be shaped. In working through this distinction, I fleshed out an as-yet only vaguely addressed type of interactional asymmetry in doctor-patient communication in primary care: structural asymmetries, through which physicians have normative rights to decide when and whether to move from one activity phase to another. I argued that when patients engage in actions that initiate a return to diagnostic inquiry once the physician has transitioned into counseling, they challenge the physician's structural interactional rights to control movement from one activity to the next and decide when such movement is appropriate; and by extension they challenge the physician's epistemic rights to have determined that enough information has been gathered for an assessment in the first place. These ideas help specify what is being accomplished when a patient resists a diagnostic assessment, but they also topicalize an area that can continue to be explored in terms of how patients and physicians orient to normative epistemic and interactional asymmetries in joint pursuit of their shared institutional goal.

Because prior studies on diagnosis resistance have identified so few cases of resistance, and because they have not gone beyond a general description of the resistance itself, Chapters 3 and 4 of this dissertation further contribute to the conversation analytic literature by significantly expanding what we know about how moments of diagnosis resistance unfold beyond the initial moment of resistance – i.e., how physicians respond and patients persist – and the interactional contexts within

which they occur. The findings from these chapters can continue to be expanded in new directions in conversation analysis in medical settings.

5.2.2 Implications for Doctor-Patient Communication

The most immediate contribution this dissertation has for doctor-patient communication is that it identifies diagnosis resistance as a distinct and discrete problem in medical encounters. As I have shown, diagnosis resistance is locally emergent, treated as socially problematic, and multifaceted in terms of the actions and practices through which it is accomplished. Conversation analysis is well suited as a research method in this context because diagnosis resistance is not as easy to identify as more clearly bounded and explicit phenomena, e.g., requests for tests or treatment. By operationalizing a definition of diagnosis resistance using conversation analysis, this study puts a name to a problem which my own personal communication suggests may resonate with both physicians and patients but has not yet been addressed by those seeking to improve healthcare communication or the physician-patient relationship. The findings from each of the analytical chapters in this dissertation also have implications in the applied arena and provide some jumping-off points for future research.

Chapter 2 showed that although patients are resisting physicians' diagnostic assessments far more often than previously thought, they are doing so in ways that continue to obscure their underlying concerns, defer to the physician to draw out or clinically pursue those concerns, and make it easy to ignore or otherwise brush off their resistance. This suggests that, despite literature suggesting patients are more engaged or empowered (Halpern 2004; Timmermans 2020), and counter to advice commonly found online for patients for how patients might "speak up" and "fight for their body" ("How to disagree" 2018; Epstein n.d.), voicing a concern about a physician's assessment is indeed a fraught undertaking. By considering *how* and *why* it is so fraught in

interactional detail, and with an eye toward the role medical authority plays, this dissertation provides a jumping-off point for health communication research tailored to how to best – and realistically – advise patients in how to advocate for themselves in primary care.

Chapter 3 looked at diagnosis resistance from the physician’s perspective. When a patient resists a physician’s assessment in the ways shown in this dissertation, they implicitly challenge the physician’s expertise and authority and risk undermining the very reason for the visit – to solicit the physician’s help in dealing with a health problem, which normatively includes assessing the nature of their problem (Starr 1982). Diagnosis resistance also interrupts the progressivity of the visit toward closing and makes a bid to return to information-gathering or even re-assess the patient’s problem; this in a context where physicians are already pressed for time. The findings from this chapter show that physicians generally respond to resistant actions in ways that prioritize a return to their own agenda rather than a pursuit of the patient’s. These findings render observable in close detail what is likely a common area of difficulty for physicians and explains one reason why physicians may report that visits with unmet patient concerns so challenging (Jackson & Kroenke 2001; Hooper et al. 2005). It also empirically contributes to, and perhaps does some work to motivate the expansion of, a relatively small and somewhat nascent area of healthcare communication research – the impact of time constraints (perceived or real) on patient-centered care (Braddock & Snyder 2005; Elder, Ricer & Tobias 2006; Mauksch et al. 2008; Solomon 2008; O’Connell, Youcha & Pellegrini 2009). Finally, the findings from Chapter 3 provide a jumping-off point for research on how different types of physician response to diagnosis resistance might influence outcomes beyond the visit itself, how physicians might deal with diagnosis resistance in a more patient-centered way, and how or whether such changes in communication improve outcomes.

However, a potentially more realistic and useful area for improvement may be physicians’ communication practices *preceding* potential moments of resistance, as revealed by the findings in

Chapter 4. As I showed in that chapter, diagnosis resistance is often preceded by divergence between a physician's and patient's assessment of the patient's condition. This may be ameliorated if physicians do observable work to bridge the resulting gap by explaining their clinical reasoning in a way that ties to the patient's theory or concerns – *before* the patient has a chance to resist. Given how rarely patients explicitly reveal their underlying concerns, it is not always possible to determine the exact nature of divergence for a patient. But this in itself highlights a potential area for intervention. It may be the case that if a physician actively pursues the patient's perspective early on, they will be able to better address patient concerns later.

Given real and perceived time constraints for physicians, further research is needed to identify practices that are both efficient and effective. But studies on related topics have shown that preparing a patient for an outcome that departs from their expectations early in the visit may reduce resistance later on (Heritage & Stivers 1999; Heritage et al. 2010), and that pursuing the patient's perspective improves resolution of patient concerns without actually lengthening visits (Henbest & Fehrson 1992; Levinson, Gorawara & Lamb 2000; Mauksch et al. 2008). More research is needed to test the effects of such communication practices – which are indeed encouraged in the patient-centered care literature (Stewart et al. 1995; Institute of Medicine 2001; Mead & Bower 2002; Epstein et al. 2005b; Illingworth 2010; Silverman, Kurtz & Draper 2013) but have yet to emerge in the data – on diagnosis resistance in primary care.

5.2.3 Implications for Medical Sociology – The Status of Medical Authority in Primary Care

In the introductory chapter to this dissertation, I argued that medical authority in society and the interactional flow of clinical encounters are deeply intertwined and have a reflexive relationship, such that medical authority *shapes* or is reflected in clinical interaction and is also reflexively enacted in how clinical interactions unfold.

In my three analytical chapters I focused primarily on how medical authority shapes or is reflected in the unfolding of diagnosis resistance in primary care encounters for new or acute health problems. In Chapter 2 I showed how patients orient to primary care physicians' authority to diagnose, and to their normative primary rights to control the flow of information during counseling, by resisting in less overt ways and working to mitigate the challenge their resistance presents to the physician's medical authority and the hearable inappropriateness of their turns. In Chapter 3, I showed that although primary care physicians orient to some accountability for their diagnostic assessments in the face of resistance – in line with findings in other conversation analytic studies on diagnosis (Peräkylä 1998) – they tend to respond in ways that nonetheless prioritize their own agenda over the patient's and, by extension, protect their epistemic authority. Finally, in Chapter 4, I argued that one of the main reasons diagnosis resistance may happen in primary care in the first place is because of divergence between physicians' and patients' assessment of the patient's problem, leading to patient concerns that go unaddressed as a result of both participants' orientations toward a legacy of normative epistemic and interactional asymmetries between them, and toward the primacy of the biomedical, disease-oriented perspective of medicine in the visit. In sum, the ways diagnosis resistance is accomplished by patients in primary care, the ways physicians respond, and the processes leading to resistance, are all shaped by participants' orientations toward physicians' expertise and authority over assessing the patient's condition.

In this section I consider what these findings can conversely tell us about the status of medical authority in primary care. First and perhaps most obviously, the fact that patients are resisting diagnosis as often as they are throws a wrench into theories that although physicians' authority over treatment may be “under siege” (Stivers & Timmermans 2020), they generally retain epistemic primacy in terms of diagnostic assessment during clinical encounters. This authority is clearly being challenged in some way. But is this merely a story of the medical profession's declining

authority over diagnosis? When considering the findings of this dissertation, the story does not appear to be so straightforward.

Returning to the analogy of the train may be useful in considering what patients are *doing* when they resist diagnostic assessments – and, just as importantly, what they’re not doing. When a physician has shifted from information-gathering into counseling, the “train has left the station” in the sense that the physician has assessed the nature of the patient’s condition and begun to give advice based on that assessment; the patient no longer has normative rights or opportunities to influence the physician’s diagnostic reasoning or how counseling is shaped by their assessment. So how do patients work to stop the train when they have lingering concerns about the physician’s assessment or its fit with their own experience or expectations?

With treatment recommendations, patients are metaphorically pulling the emergency brake, and this results in negotiations over treatment before the physician resumes progressivity toward closing (Stivers 2005, 2007; Stivers & Timmermans 2020). In that context, patients orient to having legitimate grounds for pulling the brake, and physicians align with this orientation by pausing their forward trajectory in order to negotiate with or persuade the patient. This is not what is happening with diagnosis resistance. Instead, patients are bringing up potential reasons to stop or go back (e.g., descriptions of symptoms), and deferring to the physician to decide whether indeed stopping or reversing course is warranted. If not, patients may ride along until an opportunity arises to bring up a new reason to stop or go back, or they may simply abandon their resistance and go along for the ride.

Working to make sense of what patients are doing in these moments of resistance makes relevant a consideration of different aspects of medical authority. One distinction to be made is between the medical profession’s authority over *actually* defining “the nature of reality,” i.e., diagnostic assessments, and patients’ normative *orientation* to this authority through a “surrender of

their private judgment” (Starr 1982). By resisting a physician’s assessment, patients are not (or not totally) surrendering their private judgment. This may be a logical outcome of a patient population that is more empowered, more engaged, and/or more informed about their own health than previously (Timmermans 2020). But by bringing up reasons for stopping the train and deferring to the physician to decide whether stopping or reversing course is warranted, patients are nonetheless orienting to the physician as the one with the expertise and authority to assess the patient’s problem in the first place. In this situation, patients are not necessarily challenging the physician’s power to define the nature of their problem; they’re simply declining to surrender their private judgment and take that definition “on authority” (Parsons 1951).

Another important and relevant distinction is that between the *legitimacy* aspect of physicians’ authority versus patients’ *dependence* on that authority. As Starr (1982:11) writes, “as gatekeepers into and out of various institutions, professionals acquire means of ensuring compliance quite independent of any belief in the moral basis of their authority.” Patients go to the doctor for more than just their belief that the physician knows best – they *must* visit their primary care physician to gain access to medical care: tests, referrals to specialists, treatment, and even diagnosis itself. By showing up at the doctor’s office to begin with, and then resisting physicians’ assessments in ways that defer to the physician’s judgment, patients display dependency on that judgment, and its independent clinical basis.

So perhaps patients are challenging the legitimacy of the physician’s authority. But to what extent are they challenging the legitimacy of the *profession’s* authority over diagnostic assessment? It’s important to note that patients in the data presented here are *not* challenging the nature or “realness” of diagnosis itself, nor the medical profession’s authority over the discovery and definition of particular diagnoses (Blaxter 1978; Armstrong 2011). In fact, certain kinds of diagnosis resistance, such as suggesting particular diagnostic suspicions or fears, inquiring about diagnostic tests and so

on, display an orientation toward diagnostic categories as real and legitimate. But by resisting an individual physician's assessment of their problem – even if merely to satisfy their own questions or concerns – patients are implicitly challenging the *competence* of their physician in properly investigating and/ or labeling their particular problem.

Parsons (1951) wrote that physicians' authority “rests, fundamentally, on the belief . . . that the physician has and will employ for [the patient's] benefit a technical competence adequate to help him [sic] in his illness” (quoted in Stivers & Timmermans 2020). To accept a physician's assessment “on authority,” suppressing one's own private judgment, is to not only accept the legitimacy of the profession, but also to presume an individual physician's competence to uphold the standards of the profession (Starr 1982). By expressing their own private judgment and inviting reconsideration of the fit between the physician's assessment and their own experience or expectations, patients implicitly question the physicians' competence in having properly assessed that fit in the first place. For instance, if a patient is worried that their symptoms could point to cancer, but the doctor doesn't *mention* cancer (including not ruling it out), to presume a physician's competence would mean to assume that the patient does *not* have cancer – or else the physician would have said so. But instead, patients are working to be assured, to find out for themselves, that the physician has indeed done due diligence in ruling it out.

These ideas go beyond but indeed align with prior studies suggesting that both physicians and patients display orientations to physicians as somewhat accountable to patients for their clinical reasoning (e.g., Peräkylä 1998; Heritage & Stivers 1999). I found this as well in Chapter 3, where I argued that physician practices for brushing off patient resistance without orienting to it *as* resistance is one way they may be getting around the issue of accountability altogether, since when they *do* acknowledge resistance, they typically account for their reasoning. However, it is important to note that in neither my data nor Peräkylä's do participants orient to the patient as equal in epistemic

status to the physician. Physicians are not working to persuade patients in a way that communicates their full clinical reasoning, nor are patients asking for that. Indeed, there is neither the time nor the reason for physicians to burden patients with the entire decision tree leading to their assessment of the patient's condition. Rather, participants are orienting to the relevance of physicians sharing *enough* of their reasoning that the patient can see for themselves that the physician's assessment is appropriate, especially if there is divergence between that assessment and the patient's experience or expectations.

This is not to say that patients are regularly walking into their visits with primary care physicians doubtful of, or ready to challenge, that physician's competence as a clinician. It is far more likely that the patient behavior described in this dissertation fits more within the emerging story about how patients are becoming more engaged in their own healthcare, which few would argue is a bad thing. But this shift also plays an important role within the broader history of physicians' medical authority in society. Compared to an earlier time of medical paternalism, when patients routinely accepted physicians' assessments "on authority," patient engagement vis-a-vis diagnosis resistance does undermine that authority, and points to a continued shift toward a medical context where physicians' clinical reasoning is more answerable to patient's illness experiences and expectations than ever before.

5.3 LIMITATIONS

5.3.1 Dataset

This study works with a relatively small sample size for making such sweeping claims about the nature of medical authority in US society at large. In the AMH dataset, on which the numbers in this dissertation were based, physicians worked for a single healthcare organization in Los Angeles, a geographical area that is both distinctly urban and distinctly western/coastal. Thus, this study cannot

address how participants would behave differently in other healthcare settings in the same city, let alone those in suburban or rural settings, or in other geographical regions of the US. And although the sample population is relatively diverse in terms of gender and race, patients were generally older and better educated than the general population, and two of the three clinics – the community clinics – were located in affluent neighborhoods. Studies have shown that age and education are among demographic factors affecting how patients communicate in medical settings (e.g., Croker, Swancutt & Roberts 2013), and more research is needed to investigate how diagnosis resistance might unfold among a more diverse patient population. Finally, although the group of participating physicians was fairly heterogenous in gender and race, the group skewed fairly young, and all physicians expressed support for the patient-centered care movement and a strong belief in the importance of communication in medical care. On one hand it is interesting that even this group of physicians engages in relatively non-patient-centered practices when it comes to diagnosis resistance. Nonetheless, more research is needed with a much larger and more diverse set of physicians.

5.3.2 Setting

This study is clearly centered on the medical context of primary care in the United States. As I have argued throughout this dissertation, primary care is a unique context distinct from secondary or specialty care settings, especially when it comes to diagnosis. This context is an important one, because it represents the first contact most people have with the healthcare system regarding a new, unknown set of symptoms. Primary care physicians presented with new health problems are not only often the first (and sometimes only) person to define a patient's health condition, but they are also the gatekeepers to diagnostic tests, referrals to specialized care, and treatment. From the perspective of healthcare systems, improving doctor-patient communication in primary care can drive down healthcare utilization and costs, and improve patient health outcomes (Friedberg,

Hussey & Schneider 2010). From the perspective of patients, how well visits about new health problems with primary care physicians unfold can set the tone and trajectory of care for that problem and can also influence whether and how they interact with the healthcare system in the future (Shi 2012). The findings from this dissertation, and from studies that are enabled by or built off of it, have important implications for understanding how communication unfolds in primary care, and considering how things might be improved.

But it must be emphasized that my findings here, and my arguments about the nature of medical authority in the US, may be unique to the practice of primary care. The interactional structure of visits differs across medical settings, therefore the interactional resources available to patients' and physicians' differ. There may also not be the same constraints (although presumably there *are* constraints) on what physicians are expected to accomplish in a visit, or how much time they are given to do so. Moreover, as discussed at length in Chapter 1, the diagnoses under consideration in secondary and specialty care are often far more serious – not to mention more specific and thoroughly investigated – than the diagnostic assessments delivered in primary care. It is thus likely that patients not only resist differently in these settings, but also that they have an entirely different set of concerns when it comes to the assessment of their problem in the first place. More research is needed to explore these differences.

5.4 FINAL THOUGHTS

The findings in this dissertation suggest that physicians' medical authority in clinical encounters may be in something of a liminal state, where a rise in patient empowerment and engagement is pushing up against deferment to physicians over clinical matters like diagnosis. On one hand, patients are doing more work to get their concerns about the assessment of their condition addressed. But at the same time, they are undermining their own efforts by doing so in

ways that strongly maintain an orientation to the physician's authority. Thus, although physician authority may be in decline, helped along by patients who are increasingly engaged in their own healthcare, it is the very legacy of medical paternalism that is hampering patients' efforts.

It's difficult to predict where this might lead. The continuing rise of patient-centered care might lead physicians to begin to more explicitly pursue patient concerns and address diagnosis resistance head on, leading to a further decline in authority. At the same time, institutional constraints such as increased caseloads for physicians and limits on the amount of time they can spend with each patient may limit the extent to which this happens. Further research and theoretical consideration over time will be needed to track this trajectory of medical authority, in primary care and beyond.

One thing the findings from this dissertation does point to is that, if there is indeed general agreement that medical care needs to more adequately attend to, respect, and treat as central the patient's perspective, this needs to come from physicians themselves. We can see, in the data and anecdotally, that patients want their voices to be heard and their concerns to be addressed, and often feel that this is not happening. As discussed at the outset of this dissertation, advice columns often recommend that patients speak up for themselves rather directly. But we can see in the data that patients are not doing this, which is largely shaped by their orientations to the physician's authority and the deeply asymmetrical interactional context of clinical encounters. More work needs to be done to find ways for patient-centered care practices like pursuing and attending to the patient's perspective to become a clinical reality more than the aspiration it currently is.

APPENDIX A:

Transcription Conventions

Symbols used in transcripts follow standard conversation analytic conventions originally developed by Gail Jefferson. The symbols used in this dissertation are described below.

- ?,. Punctuation is designed to capture intonation, not grammar.
Question mark indicates strong rising intonation;
Comma indicates slightly rising intonation;
Period indicates falling intonation.
- [Left-side brackets indicate where overlapping talk or behavior begins.
- (0.8) Numbers in parentheses indicate periods of silence, in tenths of a second.
- (.) A period in parentheses indicates a silence less than two-tenths of a second.
- ::: Colons indicate lengthening of the preceding sound, proportional to the number of colons.
- wor- A hyphen indicates an abrupt cut-off or self-interruption of the sound in progress.
- word Underlining indicates stress or emphasis.
- ^word A “caret” or circumflex accent symbol indicates a marked pitch rise.
- >word< Talk appearing within sideways carets is delivered faster than surrounding talk.
- °word° Talk appearing within degree signs is lower in volume relative to surrounding talk.
- #word# Talk appearing within number signs is low-pitch/ “creaky.”
- \$word\$ Talk appearing within dollar signs is delivered in hearable “smile voice.”
- <word A single sideways caret is used to indicate a “left push,” i.e. that the following sound is hearably “jumpstarted.”
- = Equal signs indicate a “latched” relationship – no silence between words or sounds.
- () Empty parentheses indicate talk too obscure to transcribe. Words or letters inside such parentheses indicate the transcriber’s best estimate of what is being said.
- hhh The letter “h” is used to indicate hearable aspiration proportional to the number of “h”s. If preceded by a dot, the aspiration is an in-breath.
- .hhh
(h) Aspiration internal to a word is enclosed in parentheses.

Aspiration transcribed with the letter “h” may indicate anything from ordinary breathing to sighing, laughing, etc.

.pt .t A dot followed by consonants indicates a click or lip smack, typically preceding talk.

((word)) Words in double parentheses indicate transcriber’s comments.

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