
Treatment decisions: negotiations between doctors and parents in acute care encounters

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When people seek medical attention for an illness, they are generally looking both for an explanation of the illness and for a solution to their or their child's medical problem (Robinson 2003). Acute medical encounters typically include both a phase of the interaction that is concerned with the diagnosis delivery and a phase that is concerned with treatment for the medical condition (Byrne and Long 1976; Robinson 2003; Waitzkin 1991). Although both the diagnosis delivery and the treatment recommendation involve the physician imparting knowledge to the patient/parent,¹ the two actions have a rather different sequential structure and are treated differently by physicians and parents. This chapter will demonstrate that, in acute medical encounters, the final treatment decision is negotiated by physicians and parents – whether implicitly or explicitly. While parents typically do not respond to diagnosis deliveries, they do routinely accept treatment recommendations. Furthermore, in contrast to diagnoses, if parents do *not* accept a treatment recommendation, this is treated as resisting the recommendation. Resistance – passive and active – is a problematic behavior with both interactional

Portions of this chapter were presented at the Institute in the Qualitative Case Study in Communication Research, University of Washington, Seattle, Washington in 2002; at the International Communication Association Convention in San Diego, California in May 2003; and at the National Communication Association Convention in Miami, Florida in November 2003. Correspondence concerning this article should be addressed to the author at the Max Planck Institute for Psycholinguistics, PB 310, NL-6500 AH Nijmegen, The Netherlands, or electronically at Tanya.Stivers@mpi.nl.

¹ In order to keep things concise, I will generally refer to parent(s) because most of the data I am relying on are pediatric. However, points being made usually refer to both patients and parents unless otherwise specified.

and medical consequences. Finally, I will discuss alternative formats for delivering the treatment recommendation, and show that it may be possible to reduce the likelihood that parents will resist the initial treatment recommendation.

Data

This chapter draws on several corpora of video- and audiotaped medical encounters from internal medicine, orthopedics, and pediatrics collected between 1996 and 2001. However, the original analysis of the practices outlined in this chapter was based exclusively on pediatric encounters (see Stivers et al. 2003 and Stivers 2005a for a full description of these samples). Relying heavily on previous analyses (Stivers 2005a, 2005b), this chapter makes use of this broad range of data in order to document that treatment is oriented to as negotiated across primary care. The examples chosen for this chapter – whether from pediatrics or from the adult context – are representative of and qualitatively similar to the cases in the original analyses on which this chapter is based.

Background

Patient participation in health care

Many countries are recognizing that the role that patients play in their own health care is an important and consequential one. Because of this, there has been much emphasis within health care policy on encouraging physicians to involve patients/parents in treatment decisions. Within the United States, the primary government health care policy document states that patients who participate actively in decisions about their health care can positively impact national health (see US Department of Health and Human Services 2000 for a description of these data). And many health policy researchers assert that patients should, whenever possible, be offered choices in their treatment decisions (Brody 1980; Butler et al. 1998; Deber 1994; Emanuel and Emanuel 1992; Evans et al. 1987; Fallowfield et al. 1990; Kassirer 1994; Levine et al. 1992). A number of American medical associations now recommend that physicians explicitly

involve patients in their decision-making. For instance, the American Cancer Society, the American Urological Association, the American Gastroenterological Association, the American College of Physicians, and the National Institutes of Health (NIH) all recommend shared decision-making for decisions surrounding cancer screening (Frosch and Kaplan 1999).

The primary rationale for these recommendations has two facets: patients have a right to, and want to, participate in the decision (Blanchard et al. 1988; Cassileth et al. 1980; Emerson 1983; Ende et al. 1989; Faden et al. 1981; Thompson et al. 1993); and patients have improved outcomes when they participate in medical decision-making, including satisfaction (Brody, Miller, Lerman Smith, and Caputo 1989; Brody, Miller, Lerman, Smith, Lazaro, and Blum 1989; Evans et al. 1987), patient health (Brody 1980; Greenfield et al. 1988; Kaplan et al. 1989; Mendonca and Brehm 1983; Schulman 1979), and patient mental well-being (Brody, Miller, Lerman, Smith, and Caputo 1989; Evans et al. 1987; Fallowfield et al. 1990; Greenfield et al. 1988). Although researchers suggest that in the acute primary care context, doctors are much less likely to involve patients in treatment decision-making (Braddock et al. 1999; Elwyn et al. 1999; Tuckett et al. 1985), this appears to be based on the assumption that a patient must be explicitly invited to participate by a physician in order to be involved in the decision process. In what follows I will show not only that parents do, typically without invitation, affect the treatment outcome through participating in a negotiation process, but also that their participation is treated by physicians as conditionally relevant.

Analysis

Responses to diagnosis deliveries and treatment recommendations

Parents and physicians alike orient to diagnoses as within the physician's domain of expertise. This is primarily evidenced by the fact that when physicians deliver diagnoses they are routinely not even minimally responded to (Heath 1992; Peräkylä 1998; Stivers 2005b). Further, physicians do not pursue parent uptake of their diagnoses. This normative environment sustains diagnosis delivery as complete and permits movement into the treatment

recommendation. By contrast, both parties orient to parents (perhaps more than adult patients) as having the right to accept or reject the treatment proposal. Thus, while diagnoses are oriented to by the participants as within the physician's domain of responsibility, treatment decisions are oriented to as the responsibility of both parties.

It has previously been argued that participants are typically oriented to treatment as the final activity of the project of solving patients' new medical problems (Robinson 2003). However, a physician's presentation of a treatment recommendation is *not* generally treated by either doctors or parents/patients as sufficient for activity closure. Both physicians and parents/patients display an orientation to parent acceptance of the treatment recommendation as relevant upon completion of the treatment recommendation (Stivers 2005b). Thus, the sequential structure of treatment recommendations typically involves a recommendation followed by parent/patient acceptance, and only then a shift to other business or closure of the encounter. For example:

(1) 2002 (Dr. 6)

- 1 DOC: .hhh Uh:m his - # - # left:=h ea:r=h, is infected,
 2 -> (0.2)
 3 DOC: .h is bulging, has uh little pus in thuh
 4 -> ba:ck, =h
 5 DOC: -> Uh:m, an' it's re:d,
 6 DOC: .hh So he needs some antibiotics to treat tha:t,
 7 DAD: => Alright.
 8 DOC: Mka:y, so we'll go ahead and treat- him: <he has
 9 no a- uh:m, allergies to any penicillin or anything.

Having just completed her examination of the child, the doctor here explains the child's diagnosis (lines 1–5). Although the doctor comes to possible turn completion most notably at the end of line 1 but also at the end of line 4 and at the end of line 5, the parent does not respond. By contrast, after the physician offers her treatment recommendation in line 6 the father accepts this with “Alright.” immediately upon possible completion of that turn constructional unit (TCU). Also notice that, once the parent has accepted, the physician, at line 8, moves from the generic discussion

of “antibiotics” to determining which type of medication can be prescribed.

Another example is shown in Extract (2). Here, the mother receipts the doctor's diagnosis of an ear infection with “Mm.” (line 3). This token offers only minimal acknowledgment of the diagnosis (Gardner 1997).

(2) 1183 (Dr. 1)

- 1 DOC: Well I think what's happened is that she
 2 has this: uh- (.) .h ear infection in her left ear?,
 3 MOM: [Mm.:
 4 DOC: -> [And we'll put her on some medicine and she'll [be fine.
 5 MOM: [Okay.

However, the parent's response to the treatment recommendation, is “Okay.” (line 5). This token – particularly with final intonation – accepts the doctor's recommendation, thereby treating it as a proposal which makes acceptance relevant, and not as an informing. The parent's two different receipt tokens offered in close proximity provide evidence that parents orient to diagnoses and treatment recommendations as actions that make relevant different sorts of responses.

Withholding acceptance as passive resistance

That parents routinely accept physicians' treatment recommendations but not diagnoses is one form of evidence that treatment is a domain of joint responsibility and that parents participate in treatment decisions in a way that they do not participate in diagnosis. Further evidence lies in physicians' pursuits of acceptance when none is forthcoming. For instance, see Extract (3) from an internal medicine practice. The diagnosis is delivered across lines 1–7. The patient receipts the information with continuers at lines 3, 6, and 9. In line 10 the physician moves into her treatment recommendation, which is also receipted with continuers in lines 12, 14, and 16. Note that the physician shifted from diagnosis delivery to treatment recommendation in the face of having received only continuers from the patient. Once in the treatment

recommendation phase, however, the physician pursues the patient's acceptance.

(3) SG 1211

- 1 DOC: I don't ^think- to be honest I think you
 2 probably had this infection. .hh=
 3 PAT: =M[m hm,
 4 DOC: [an:d=uh it's- whatever you had it's: v_i ral
 5 infection:, your bo[dy is trying to get rid of
 6 PAT: [Mm hm,
 7 it,
 8 DOC: .h[h
 9 PAT: [Mm h[m.
 10 DOC: [An' you just need uh little bit of push.
 11 (0.4)
 12 PAT: [Mm hm,
 13 DOC: [to help you to get over this cough:
 14 PAT: Mm hm,
 15 DOC: I don't think you need antibiotics?,
 16 PAT: Mm hm,
 17 DOC: -> I (didn't)/(don't) see any si:gns .h indicati:ng
 18 -> (.) ya know- (.) uh: for thuh [antibiotics.
 19 PAT: [#huh huh# ((cough))
 20 PAT: hm [kay,
 21 DOC: [.hh Uhm you probably need some strong cough
 22 medicatio:n=so[me
 23 PAT: [Mm hm,
 24 DOC: expec_torant, strong_er expec_torants, [.hh ai- to=
 25 PAT: [Mm hm,
 26 DOC: =clear your airways from thuh phle:gm,
 27 DOC: -> .ml[h and uh: (m) also at ni:ght I would use uh=
 28 PAT: [Mm hm,
 29 DOC: -> =cough suppressant which I usually: (.) am hesi_tant
 30 -> to u:se_
 31 DOC: -> .hh [but only at ni:ght. (.) so you can go t:o s:-=
 32 PAT: [Mm hm,
 33 DOC: -> =[uh to slee:p an:' not wake up with (th') cough.
 34 PAT: =[Mm hm,
 35 PAT: Mm hm?,
 36 DOC: -> Okay?
 37 PAT: Mkay.

First, at lines 17–18 the physician offers a rationale for her assertion that the woman does not need antibiotics. She accounts for the

recommendation, which is one way of pursuing acceptance (Stivers 2005b). In response, the patient offers “hm kay,” but with continuing intonation, this offers acknowledgment but does not fully accept the treatment. Second, the physician offers an alternative medication (“strong cough medicatio:n”, lines 21–22, 24, and 26), but this is receipted only with continuers. Thus, the patient here treats the physician as not yet done with her recommendation. The physician then goes on to recommend a third medication beginning at line 27 (“also at ni:ght”). Note that this recommendation is offered only after no uptake following line 26. Although it is not uncommon for physicians to offer multiple recommendations, it is notable that additional recommendations frequently appear at interactional junctures such as this, where there has not been an acceptance of the treatment proposal. This is further pursued with the reinvoation of “only at ni:ght.” in line 31, which works to recomplete the sequence and thus pursues sequence closure (Schegloff, in press). Finally, at the end of the treatment in line 35, the patient still offers only a continuer in response. At this point the physician overtly solicits acceptance with an upward-intoned “Okay?” in line 36.

Extract (4), from a pediatric encounter, is an example which shows that silence or continuers communicate a withholding of acceptance in a sequential environment where acceptance is normatively required. At this point, the physician has completed an in-office throat culture and is waiting for these culture results. She begins her treatment recommendation with suggestions that are irrespective of these culture results. Throughout this explanation the parent says very little. At each single arrowed line there is an opportunity for the parent to respond to the physician's recommendation – acceptance is a relevant action. However, in each case the parent does not offer acknowledgment, let alone acceptance.

(4) 2020 (Dr. 6)

- 1 DOC: #Mkay:::.# so::,=h (0.5)
 2 DOC: Tlk=.h Let's see: what=thuh results of this i:s,=h
 3 while we're waiting for tha:::t,
 4 DOC: .h So no matter what the result i:s, h she does
 5 ha:ve uh:m hh redness in 'er throat, an' looks
 6 like she has pharyngitis, <whether it's from bacterial
 7 -> or from virus,

- 8 DOC: -> .hh So:: uhm I want her to do mouthwashes?,
 9 DOC: -> .h Gargling at ho:me?,
 10 DOC: -> Really deep gargling. (.) All the way back.
 11 => #Aghghghgh.# All thuh way back of thuh throat, okay:?,
 12 DOC: -> .hh Do it as many as- time as you can.
 13 (.)
 14 DOC: -> Three.. four times uh day. Especially after eating.
 15 => Mokay,
 16 DOC: -> .h That clears it out an' that makes it feel better.
 17 Mokay,=you can do it with salt water:, you can do it
 18 -> with Sco:pe,
 19 DOC: -> .hh whatever mouthwash: flavor that she likes.
 20 DOC: -> .hh So lets do that:,
 21 DOC: => .hh Give 'er uh soft diet:?, Mokay:, Don't
 22 give her anything heavy, nothing oily:,
 23 -> French fries, (.) fried chicken.. hamburgers,
 24 DOC: => .hh Nothing spicy.=h for uh couple days. Okay:,
 25 DOC: .h Cuz it's gonna hurt every time she swallows those
 26 -> kind uh stuff.
 27 DOC: -> .hh Let's give 'er lots of liquids at ho:me,
 28 (0.6)
 29 DOC: -> .hh Give 'er: water, jui:ce, whatever she wants to drink.=h
 30 DOC: -> Ice cream is okay:, That will make her feel better:,
 31 DOC: -> .h Popsicles,
 32 (.)
 33 DOC: -> That makes you feel better,
 34 DOC: => .h Mokay:?,
 35 DOC: -> .h Maybe some mashed potatoe::s, you know
 36 -> (so)/(it's uh) soft diet. as uh general.
 37 (.)
 38 DOC: => Yogur:t, things like that. Nokay:,
 39 DOC: -> .hh Uh:m.. and you're just gonna have to rest.
 40 (.)
 41 DOC: You know?,
 42 (.)
 43 DOC: She's gonna have to rest.
 44 MOM: Yeah.=
 45 DOC: =No more running arou:nd an' - (.) ya know staying
 46 -> up la:te, an' things like that.
 47 DOC: .h You're just gonna have==t' take lots of na:ps,
 48 -> an' re:st, throughout thuh weekend.
 49 DOC: => .h Mokay:, ((Doc moves to look at rapid strep culture)

This physician seeks acceptance of her recommendations for mouthwashes (line 8), a soft diet (line 21), liquids (line 27), and rest

(line 39). We can see this in several ways. First, similar to Extract (3), she provides accounts for her recommendations (e.g., lines 16, 25, 30, and 33). She also restates her treatment recommendations (e.g., lines 10–11, 35–36, 43, and 47–48). Third, she adds additional treatments (lines 21, 27, and 39). Fourth, she can be seen to pursue acceptance with rising intonation at the end of TCUs such as in lines 8, 9, and 21 (Sacks and Schegloff 1979; Schegloff 1996d). That these locations were designedly in pursuit of acknowledgment can be seen, for example, in the doctor's repeat of lines 8 and 9 in line 10 and the respecification with "All the way back." (also in line 10). There is still further pursuit in line 11, first with the demonstration of gargling, and second with the redoing, yet again, of "All thuh way back of thuh throat," and then with a more direct request for acceptance with "okay:?,".

Similarly, through the physician's use of three-part lists the physician also hearably invites the parent's uptake because these lists project completion and have been shown to be strongly designed for recipient uptake (Heritage and Greatbatch 1986; Jefferson 1990). For example, at the end of line 19 the doctor reaches the third item of her projected three-part list and thereby implicates confirmation. A similar list is in line 29, but, as before, the parent does not offer any uptake.

As in Extract (3), the physician actively pursues the parent's acceptance through other means. For example, in the double arrowed lines, the doctor can be seen to pursue acceptance with various forms of "okay." The physician also changes her addressee from the mother to the child (see lines 33 and 39). This change in addressee also appears to be designed to elicit acceptance even if that is from the child.² And, in line 41, the physician pursues a response with "You know?,". However, it is not until line 44, after multiple pursuits and a change in addressee back to the mother, that she minimally agrees with the doctor's treatment recommendation of rest.

In this section I have shown that physicians work diligently to elicit parent acceptance before closing the activity of recommending treatment. We saw that their pursuits of acceptance

² If the physician had elicited agreement from the child – which is explicitly sought – this might have helped get a somewhat coerced acceptance by the mother. It is in this sense that I see this as a practice for pursuing *parent* acceptance.

include extending the activity with accounts, returning to prior activities such as diagnostic findings in support of the treatment recommendation, offering additional recommendations, pursuing acceptance with rising intonation, or, more explicitly, with variations on "Okay?". Thus, a failure to accept is heard as withholding acceptance; and physicians regard it as passive resistance (Heritage and Sefi 1992) to their proposed treatment. Thus, passive resistance is one interactional resource through which parents/patients initiate a negotiation of the treatment decision. This argument relies on a normative structure of treatment recommendations to suggest that even "doing nothing" in a particular sequential environment can be a consequential form of participation and can affect treatment decisions.

Active resistance

Whereas passive resistance works purely in a second/responsive sequential position, active resistance makes relevant a next action by the physician, so it is both a responsive and an initiating action. This makes it a stronger type of resistance. Despite these differences, either form of resistance puts the physician in a position of working to "convince" a parent to accept the proposed treatment recommendation, or offering the parent possible or actual concessions because of the normative orientation that parents/patients must accept treatment recommendations before physicians proceed to the next activity in the visit. Through either type of resistance, parents hearably take a position against the treatment they are being offered. In the pediatric data in particular, parent resistance is typically against an over-the-counter or non-prescription treatment plan. In the following instance, the entry into a negotiation is brought to the surface of the interaction. Here, after the physician states his position against antibiotics in line 4, the father resists by offering a narrative of his own illness experience (lines 6, 10, 12, 14, 17-18, 20, 23, 25, and 27).

(5) 32-28-03

- 1 DOC: I th:ink from what you've told me (0.2) that this is
 2 pro:bably .h uh kind of (0.2) virus infec[tion,
 3 DAD: [Uh huh,

- 4 DOC: (0.4) th:at I don't think antibiotics will ki:ll,
 5 (0.2)
 6 DAD: -> Well-
 7 DOC: [Thee other-
 8 DAD: [()
 9 DOC: >Go=ahead.<
 10 DAD: -> Yeah. .hh () I had it- I had thuh symp[toms
 11 DOC: [I understand.
 12 DAD: -> Three weeks ago.
 13 DOC: [Right.
 14 DAD: -> [.hh An:d I've been taking thuh over the counter cough
 15 -> [()
 16 DOC: [(Good.)
 17 DAD: -> Uh s- () coughing syrup, Nothing take away. hh
 18 -> Especially my sor- my [th- my throat was real=
 19 DOC: [Mm hm
 20 DAD: -> =sore [for (awhile- et- that) w:eek.
 21 DOC: [Uh huh
 22 DOC: °Right,°
 23 DAD: -> an:d (.) I start taking thuh antibiotic (0.5)
 24 INF: eh he ((cry))
 25 DAD: -> Yesterday.
 26 DOC: Right,
 27 DAD: -> And it (.) seemed to take care of the problem.
 28 DOC: [(Well) that's why we're doin' a throat [culture.
 29 DAD: [() [Yeah.
 30 DOC: [is TUH SEE if they need antibiotics.
 31 DAD: [() Yeah yeah.
 32 (0.2)
 33 DOC: Cause <I don't th::ink they do.
 34 DAD: O[kay,
 35 DOC: => [Now if you (.) absolutely insist. I will give you
 36 => antibiotics.. but [I don't think that's the right=
 37 INF: [#eh::#
 38 => medicine for 'em,
 39 DAD: No I'm not saying- I'm not saying it- (0.2) don't
 40 get me wrong but- I'm sta- trying tuh tell you the
 41 [history of ()
 42 DOC: [I understand, I- I heard [you when you told me,
 43 DAD: [Yeah.
 44 DOC: I under[stand,
 45 DAD [Uh huh,
 (INF = infant)

In lines 23, 25, and 27, the father builds a case that antibiotics solved his own illness. This narrative is positioned at a place where

acceptance of the treatment recommendation is due, and thus is hearably resistant. Through the narrative, the father implies that antibiotics would be helpful for his two sons, who are ill with “the same thing” (as he mentioned earlier in the encounter). The physician’s response shows his understanding of this implication as he explains that antibiotics are a possible treatment, and that this is why he performed a throat culture. Moreover, in lines 35–36 and 38, the doctor offers to prescribe antibiotics against his medical judgment if the parent insists. Note that the physician here overtly acknowledges the impact of parent pressure: if the parent continues to press, he will provide the antibiotics despite the fact that they would, in his opinion, be ineffective and thus inappropriate.

This case thus offers two types of evidence for the importance parent/patient participation plays in these encounters. (1) The parent displays in his active resistance that his stance towards the treatment matters. He takes a position which, though implicit, displays himself to be in favor of antibiotics and opposed to over-the-counter treatment. (2) The doctor’s explicit acknowledgment that he will prescribe if pressured, offers evidence that for physicians, parent participation matters and can alter a treatment decision even when that participation takes this form rather than a response to an inquiry about preferences.

Another example is taken from an orthopedic clinic where a physician is seeing a woman for shoulder pain. Here, the physician recommends two types of treatment, beginning in line 1. The first involves physical therapy (lines 1–5). Although there is no verbal uptake at line 6, note that the physician had projected at least two treatment recommendations through his numbering of them. Using “number one” implies that there will be a next. Thus, acceptance is not due yet, though the patient nods in provisional (or “thus far”) acceptance (line 6). The second type of recommendation is “tuh let me give ya uh little injection right here.” (lines 7–8). In response to this recommendation, the patient bodily recoils (line 10), and vocally offers a very affective high-pitched “Mm:.” (line 11), which is treated immediately by the physician as resistance.

(6) SG 901

- 1 DOC: SO WHAT I’D LIKE- what I would recommend
2 that we do is number one is that you get

- 3 some formal physical therapy tuh work on
4 some exercises.an’ I have uh little
5 [sheet that we’ll go over,
6 PAT: [((nodding))
7 DOC: .hh And number two I’d like you tuh let me give
8 ya uh little injection [right here.
9 DOC: [((pointing at shoulder model))
10 PAT: [((wraps arms around body; leans back))
11 PAT: -> (↑↑Mm:.) ((high pitch))
12 DOC: If you don’t wanta do it we don’t [(hafta do.)
13 PAT: [No: no no.
14 (I- i- if you hafta you hafta I- I)
15 just #ugh#.
16 (0.5)
17 DOC: If you wanna wai:t (.) I mean we can do it
18 next time,
19 (.)
20 DOC: But it- I- I think most of tuh time what
21 happens is is I put three medicines in
22 there oka:y,

Immediately following this active resistance, the physician backs down from his recommendation for an injection. He shifts from offering it as what he’d “like” to do, to making it contingent on her own wishes (line 12). Slightly later, after the patient exhibits resigned acceptance (lines 13–15), he offers to at least delay the injection until another visit (lines 17–18). Although ultimately the patient does agree to the injection in line with lines 13–15, both of the physician’s modifications to what he originally proposed underscore that the treatment outcome is a product of negotiation.

That physicians respond to parent resistance with concessions (whether that be delaying a particular recommendation or eliminating it altogether, both of which were seen in the extract above, or offering treatment that had not been previously offered at all) is potentially problematic not only from an interactional perspective but also from a medical perspective. For instance, in some cases, physicians alter their treatment recommendations from one type of medication to another, and this can be particularly concerning when that change involves a medication such as addictive pain relievers, medications with known side effects, or antibiotics, (Extract 5) because of the current national and international issue with bacterial resistance to antibiotics (Baquero et al. 2002; McCaig and Hughes

1995; Neu 1992; Reichler et al. 1992; Schwartz 1999; Whitney et al. 2000; Wise et al. 1998) which has been escalated in no small part by inappropriate prescribing of antibiotics for viral infections (Cristino 1999; Deeks et al. 1999; Gomez et al. 1995; Nava et al. 1994; Watanabe et al. 2000).

Although complete reversals in treatment recommendations are rare, that they happen at all provides strong evidence for the power of parent resistance and the critical role that parent/patient acceptance of the treatment recommendation plays in the treatment decision. The negotiation activity, in order to generate parent acceptance, can be quite protracted, and concessions on the part of physicians are dramatic. An instance is shown in Extracts (7a)–(7f). Here, in lines 1–2 of (7a), the physician recommends against antibiotics, but there is no parent acceptance. The physician expands her treatment recommendation against antibiotics in line 3 with an increment concerning the duration of antibiotic treatment that would be required (Schegloff 2001). The parent does not accept here, either. The physician then offers an alternative type of treatment: eye treatment (line 4). This is not accepted, and a third treatment is offered in line 5 (a decongestant). This recommendation is followed by an account (lines 7–8).

(7a) 2019 (Dr. 6)

- 1 DOC: .hh So: uh:m a- at this time I don't wanta commit 'er to:
2 antibiotics.
3 DOC: Like two weeks, or three weeks, or whatever?
4 DOC: .h I think I'll go ahead and treat her for the eye:s?,
5 an' I wanta give her some decongestant.
6 (.)
7 DOC: .hh So that would, suck out all that, um,
8 secretions?=
9

During the next 45 lines of talk (data not shown) the parent continues to withhold acceptance and thus passively resists the non-antibiotic treatment being proposed. She inquires about decongestants and what forms they come in (i.e., liquid or pill) but does not accept them. Then, at line 54, she inquires about the treatment for her daughter's eyes. The next component is shown in Extract (7b):

(7b) ((45 lines following 7a))

- 54 MOM: [And then for conjunctivitis is there [(another one?), or_]
55 DOC: [She needs uh:m.]
56 She needs eye drops.
57 (0.4)
58 DOC: Antibiotic eye drops.
59 (.)
60 DOC: Mkay:;=h=An' she's gonna hafta put- you're gonna hafta put-
61 (.) few drops i:n. several times uh da:y.
62 DOC: .hh An' that will clear her redness:; an' that (will) get
63 rid of all that goopy: stuff. that she's having.
64 (1.0)
65 DOC: Mkay:?
66 (0.2)
67 DOC: .h ^But otherwise her ears look really goo:d,
68 MOM: Yeah [(her) ears alwa[ys look good.
69 DOC: [.hh [Her: chest sounds goo:d,
70 DOC: Uh:m, .hh- Ya know i- She doesn't look like uh:m (.)
71 Why don't we go ahead and try thuh decongestant first.
72 (.)
73 DOC: Mkay:;
74 DOC: An' if you don't think there's any: improvement with
75 thuh decongestan:t, .h an' you think she still has s:-
76 you know (-) getting all the secretions ba:ck, .h [you know=
77 MOM: [Mm hm.
78 DOC: =an' if she has:=signs of fever:; .h you know at that ti:me
79 we'll go ahea:d, but at this ti:me, you know she's (uh)
80 she's afebrile no[:w,

Here again, the parent passively resists the treatment suggested for conjunctivitis (following lines 56, 58, 61, and 63). Similar to other instances, the physician works to secure her acceptance. Note in particular the account for the eye drops recommendation in lines 62–63 and the questioning “Mkay:?” (line 65) which is positioned following a full second of silence and still does not receive acceptance. Here the physician retreats to her examination findings, restating them (lines 67 and 69). The mother resists this as a rationale for the treatment by stating that “(her) ears always look good.” (line 68). The physician does not take up this resistance from the mother, but instead reasserts her treatment recommendation in line 71. The parent again passively resists even after further explicit pursuit (line 73). The physician then moves into a point at which she would consider

offering antibiotics – a future concession. This future concession would be possible if the child, as the doctor says, has secretions or a fever. However, these are precisely the symptoms which brought the parent in to the physician in the first instance. The parent actively resists this since, as a condition for prescribing, the parent conveys her understanding that the condition has already been met. See Extract (7c):

(7c)

- 81 DOC: . . . afebrile no[:w,
 82 MOM: [(Well) she's had uh low-grade temp f- on
 83 [an' off (for) thuh past couple day:s- (.) Uh:m. (0.5)
 84 DOC: [Mm hm:,
 85 MOM: She never- She- (0.5)
 86 DOC: Mm hm[:;

The mother actively resists the denial of antibiotics (most recently invoked through the mention of “at that ti:me we'll go ahead, but at this ti:me,” lines 78–79). She actively resists citing that the condition of fever, which the physician indicates might, if present, be enough to warrant a prescription, has been present at home (lines 82–83). She then recounts previous experiences where medical encounters have failed to detect a temperature when one did exist (beginning in line 85 and extending six lines beyond – data not shown).

The mother then returns to her active resistance on the count not only of a fever being present (line 93) but also on the grounds that her daughter is otherwise behaving abnormally (lines 95 and 97).

(7d) ((six lines following [7c]))

- 93 MOM: But anyway she's had low-grade temp [(an' uhm),
 94 DOC: [Mm hm.
 95 MOM: (1.1) just really hasn't been hersel:f. It's- it's- It's:=
 96 DOC: =M[m hm.
 97 MOM: [(ya know)/(even) more than: uhm (1.5) thee eye thi:ng.
 98 DOC: Uh hhh:,
 99 MOM: <I mean I usually don't- I- I usually wait to bring her in
 100 at least until [().
 101 DOC: [You wait unti- Yeah:.,
 102 DOC: .hhh Uh:[m-
 103 MOM: [Cuz it's such a big deal to come here [()
 104 DOC: [Yeah:=h

- 105 I mean: if you wa:nt ya know- I mean she looks.=
 106 MOM: =Can I at least have thuh prescription an' I'll decide
 107 whether or not to fill it, i[n a couple day:s,
 108 DOC: [t.k
 109 DOC: For the antibiotics[:?
 110 MOM: [Ye[ah.
 111 DOC: [Uh::m. I really don't like to do tha:t,
 112 because: I mean .hh She doesn't look: like she has sinusitis:.
 113 Ya know?,
 114 (.)
 115 DOC: Uhm, if you really wanta be su:re we can go ahead and
 116 DOC: take: x rays to make su:re if it's really opacify:,
 117 ->
 118 DOC: .hh cause unnecessary treatment for sinusitis: she can
 119 -> get resistant to uh lot of those antibiotics?,
 120 -> uh lot of those bugs. I mean.
 121 DOC: -> .hh An:d it's- it's not really good for her:.
 122 -> (1.0)
 123 DOC: So:: we try to minimize: ya know- treatment until
 124 -> it's really necessary.
 125 -> (.)

The implicit claim being made by the parent in lines 95 and 97 appears to be that the girl is “sicker” than the doctor’s treatment recommendation would suggest. In lines 99–100 and 103, the mother claims to normally “wait” before visiting the doctor, thus displaying “troubles resistance” (Jefferson 1988), that she is not a mother who rushes her child to the doctor (see also Halkowski this volume; Heritage and Robinson this volume). Again, the implication is that the child’s condition is more serious than the doctor’s treatment recommendation would suggest. In response, the physician begins a turn that appears more concessionary. She first agrees with the parent with “Yeah:,” (line 104) and then with “I mean: if you wa:nt ya know-”. Note that, as a turn beginning, this is very similar to “If you absolutely insist” discussed in Extract (5). Both beginnings frame the forthcoming response as a responsive concession and thus co-implicate the parent in the revised treatment recommendation. So far, the parent has not yet explicitly stated anything that she wants or expects, but she has passively resisted the physician’s treatment recommendation by withholding acceptance, and actively resisted the treatment recommendation by implying that her child is sicker than the doctor is prepared to recognize.

However, the concessionary frame is abandoned in favor of a less concessionary "I mean she looks.", which, given the no-problem physical examination that preceded this discussion, is likely to be heard as headed for an evaluation consistent with this, and inconsistent with prescribing antibiotics. It is at this point that the mother's strongest form of treatment resistance comes – an overt request for antibiotics in lines 106–107. This not only calls into question the treatment recommended so far but specifically challenges the physician's assertion earlier in Extract (7a) that she does not want to commit the girl to antibiotics at this point.

The mother's request "Can I at least have *thuh* prescription" treats the prescription as a minimal form of action. This is accomplished with "at least" and by coupling this initial proposal with a second unit of her turn "an' I'll decide whether or not to fill it, in a couple day:s," claiming some measure of autonomy and discretion (i.e., that she would not immediately fill the prescription and give her child antibiotics and could further determine whether and when to fill the prescription). The doctor denies her request in line 111, but does offer a concession: they could perform an X-ray that would potentially clarify whether or not the child should *appropriately* be treated for sinusitis (lines 115–116). In addition, the physician cites the inappropriateness of treating this condition with antibiotics and the general need to avoid inappropriate prescribing as an account for her recommendation against antibiotics. Note that here the account, part of a typical dispreferred turn insofar as it works to deny a request (Pomerantz 1984a), also works to pursue parent acceptance since, once again, acceptance is relevant.

The mother accepts neither the physician's rejection of antibiotics nor the concession. At each arrowed line the mother withholds acceptance of the physician's recommendation. The mother continues active resistance across the next stretch of interaction (see below). Here, after the doctor again returns to outline a situation in which she would concede and prescribe antibiotics – if the girl "looks really -ba:d," (line 126) – the mother asserts that her daughter never looks bad (lines 128–129). She goes on to claim that her daughter is not herself, thus implying (again) that her daughter is sicker than the physician is recognizing. This begins in line 128 with "I mean she can be really sick and she never looks-" and continues across the 20 lines of data not shown.

(7e)

- 123 DOC: So:: we try to minimize ya know- treatment until
 124 -> it's really necessary.
 125 -> (.)
 126 DOC: You know of course if she's s- you know looks really -ba:d,
 127 [then I'll go ahead.
 128 MOM: [(see she ne-) 'she never looks: ba:d. I mean
 129 [she can be really sick and she never looks-
 130 DOC: [Mm hm:,
 131 DOC: Mm hm[:
 132 MOM: [You know: I've taken her in here with:

((20 lines: examples of girl not acting sick but having infections))

- 153 MOM: And plus it's her (t=her:) uhm (0.6) tlk (0.4)
 154 Uh:hm_(0.5) °What'm I tryin' t' say:-° Emotionally.
 155 MOM: (I [mean she's been) .hh (0.8) t- you know more 'n more=
 156 DOC: [Mm hm:,
 157 MOM: =tjre:[d,
 158 DOC: [Mm [hm:,
 159 MOM: [And more 'n mo:re (.) upset easily- [an' stuff:
 160 DOC: [Mm hm,
 161 MOM: over *thuh* past couple weeks, [an' it's- it's just been
 162 DOC: [Mm hm:,
 163 MOM: =building an' building an' bui[lding.
 164 DOC: [Mm hm.

The mother appears to escalate her claims about how sick her daughter is by invoking the emotional and psychological realm (lines 153–155, 157, 159, 161, and 163), especially through her repetition and intensification of "building" (line 163).

Finally, the physician works to close the activity after what is now over 160 lines of negotiation over treatment. Note that if the mother had agreed readily to the treatment following the recommendation shown in Extract (7a), this activity might well have been closed virtually immediately. Now, the physician offers yet another concession – a willingness to talk to the girl's regular physician (lines 167 and 170).

(7f)

- 163 MOM: =building an' building an' bui[lding.
 164 DOC: [Mm hm.
 165 DOC: .tlkhh Who: usually sees her.

- 166 MOM: Doctor Hilton.
 167 DOC: .hh Uh:m lemme call him an' see what he uhm says.=
 168 MOM: =Oh is h[e around (today?)
 169 DOC: [Okay?
 170 I don't know if he's arou:nd but I'll=lemmme try to call
 171 him. .hh because: uh:m.
 172 MOM: He's not [().
 173 DOC: [Tlk I really don't want to treat 'er.
 174 (0.5)
 175 DOC: Uhm but then I've only seen her first time.
 176 DOC: This is my first time seeing her so I really don't
 177 know how she (.) you know i:s,
 178 DOC: .hh So let me call 'im an' see: what he sugge:st,
 179 DOC: h An' the:n we'll go from there.
 180 (.)
 181 DOC: [Does that sound okay?
 182 MOM: [°Okay.°
 183 MOM: Sure, if you [can (reach) him £it sounds great.£

Even here, after proposing to call the child's regular doctor, the mother is resistant (line 174) when the physician re-raises her treatment recommendation in line 173. However, when she proposes, as an alternative, that she will "see: what he sugge:st," in line 178 and make a decision at that point (line 179), the mother acquiesces to the proposal only when the doctor pursues acceptance in line 181 with "Does that sound okay?" Even then the acceptance is conditional (in line 183 with "Sure, if you can (reach) him £it sounds great.£")

Ultimately, the physician cannot reach the girl's regular doctor, and she prescribes antibiotics for the girl despite having diagnosed only conjunctivitis, having explicitly rejected a sinusitis diagnosis, and having repeatedly expressed a desire not to treat the girl with antibiotics.

This section has focused on a second type of resistance – active resistance – to a physician's treatment recommendation. We have seen that active resistance is stronger than passive resistance because it initiates new sequences and thus makes a response from the physician conditionally relevant. This puts the physician in a place where he or she must deal with closing the treatment recommendation sequence as well as with securing acceptance from the parent before

the visit can progress to the next activity and/or visit closure. Because of this, resistance can be understood as a communication practice through which parents can, intentionally or unintentionally, place pressure on physicians to alter their treatment recommendation. This is a critical form of patient/parent participation that may not ordinarily be recognized as playing a role in shaping treatment outcomes.

So far, this chapter has shown that treatment recommendations involve a negotiation between physicians and patients/parents. When treatment proposals are accepted, the relevance of that acceptance is not readily observable. It is thus primarily through deviant cases where acceptance is not forthcoming, and resistance – whether passive or active – is present, that the sequential structure and thus the relevance of parent participation becomes observable. The cases shown here provide evidence that treatment recommendations are not the result of an algorithm based on clinical findings alone but rather are subject to the influence and pressure of parent behavior and must be worked out in the medical encounter through the interaction.

This analysis has been based primarily on evidence from pediatric encounters, but a brief examination of internal medicine and orthopedic interactions – as illustrated in Extracts (3) and (6), respectively – suggest that negotiations and the practices involved are characteristic of treatment recommendations across acute primary care encounters. One of the issues this raises has been adumbrated already. What are the dangers of negotiations between physicians and patients? Previous research in pediatrics shows that when parents actively resist a physician's treatment recommendation, physicians are more likely to report that they perceived the parent to expect antibiotic treatment (Stivers et al. 2003). Because prior research has shown physicians to be more likely to prescribe antibiotics inappropriately when they perceive a parent to expect antibiotics (Mangione-Smith et al. 1999), there are both medical and social reasons for wanting to avoid or minimize parent resistance. The next part of this chapter examines alternative formats for delivering the treatment recommendation that appear directly related to whether or not parents actively resist the treatment recommendation.

The format of treatment recommendation

If we return to examples already shown in this chapter, we can see that physicians tend to offer their treatment recommendations in one of two main ways: either as a recommendation *for* or *against* a particular treatment. The most common delivery format for treatment recommendations is for the physician to recommend *for* what is to be done for the patient's problem. We observed this format in Extracts (1), (2), and (6). See Extract (8), previously shown as Extract: (1)

(8) 2002 (Dr. 6)

- 1 DOC: -> .hh So he needs some antibiotics to treat tha:t,
 2 DAD: Alright.
 3 DOC: Mka:y, so we'll go ahead and treat- him: <he has
 4 no a- uh:m, allergies to any penicillin or anything.

In line 1, the physician delivers her treatment recommendation, formatted as a recommendation for how the boy should be treated (line 1).

In contrast to the recommendations *for* treatment, physicians also relate treatment recommendations negatively – by recommending *against* treatment. Recommendations that are formatted in this manner recommend against either a class of treatment or a particular treatment, as in Extracts (3), (4), (5), and (7). Here is Extract (9) as an example, which is Extract (5) repeated:

(9) 32–28–03

- 1 DOC: I think from what you've told me (0.2) that this is
 2 pro:bably .h uh kind of (0.2) virus infection,
 3 DAD: [Uh huh,
 4 DOC: -> (0.4) tha:t I don't think antibiotics will ki:ll,
 5 (0.2)
 6 DAD: Well-

Here, the physician identifies a treatment but then negates it with “tha:t I don't think antibiotics will ki:ll,” (line 4). Although the named treatment is potentially relevant, treatment is being oriented to as relevant, the parent is not offered a solution but rather is told which solution is not an option.

As mentioned early in this chapter, previous research has argued that parents and physicians alike orient to the relevance of treatment following a diagnosis delivery. When treatment is not immediately forthcoming, patients pursue a treatment recommendation (Robinson 2003). Although this pattern is present across the different primary care data I have examined, more prominent is that some treatment recommendations are proposed by physicians but are responded to by parents as though they are insufficient. In what follows I will expand on what parents treat as minimally sufficient as compared to insufficient.

Insufficient treatment recommendations. Parents respond to treatment recommendations as insufficient when the recommendation – whether implied or stated – “1) fails to provide an affirmative action step, 2) is non-specific, or 3) minimizes the significance of the problem” (Stivers 2005a). For instance, see Extract (10). Having just reported non-problematic physical examination findings for a girl who presented with upper respiratory cold symptoms, the physician states “she's gonna get better on her ow:n,” (line 1). With this statement, the physician orients to the relevance of “treatment-related actions” (Robinson 2003:45); however, he does not provide a treatment recommendation that is oriented to as sufficient by the caregiver.

(10) 16–07–07

- 1 DOC: Uhm: she's gonna get better on her ow:n,
 2 (.)
 3 DOC: I don't see any ear or throat infection,
 4 GPA: -> So just (.) f:lu:ids and °you know°.=
 5 DOC: =Flu:ids an' re:st an' kinda thuh (0.4) common
 6 sense kinda things,
 7 GPA: She's okay to go to school tomorrow_.

Evidence is provided in the grandfather's response: he inquires about treatments that *could* be provided (line 4). This action displays his orientation to the physician's intimation of no treatment as an insufficient treatment recommendation and, moreover, makes relevant an affirmative and specific treatment recommendation from the physician. The physician does then provide this in line 5. However, he maintains a rather vague orientation towards the sort of mundane treatments that could be used in such a case. These types of treatment

recommendations are routinely problematic, and here, although it is adequate for sequence closure, it nonetheless yields continued confusion regarding the health status of the child as evidenced by the grandfather's question in line 7.

This example suggests that parents are oriented to a minimally sufficient treatment recommendation as necessarily including a specific next action step. I argue that it is precisely for this reason that treatment recommendations that recommend *against* particular treatment are more likely to be resisted. If a treatment is ruled out, then by definition no specific next action step is provided, which leaves parents in a position of pursuing a sufficient treatment recommendation. For example, see Extract (11). After the physician recommends against antibiotics (line 5), the mother inquires about a medication that she can provide (line 9).

(11) 32–27–08

- 1 DOC: .hh So: I think it's just (.) one uh thuh (.)
 2 thi:ngs: kids get one thing after another sometimes,
 3 MOM: M[kay.
 4 DOC: [Nothing serious here,
 5 DOC: .mh Nothing that I can see that an antibiotic would help,
 6 MOM: Okay;
 7 (.)
 8 DOC: [Uh:m
 9 MOM: -> [So uh:m (.) should I continue with thuh Tyleno:l? er-
 10 DOC: Tylenol if he's uncomf_ortable.
 11 (.)
 12 DOC: [With fev_er 'n (0.2) headache,
 13 MOM: [(*kay
 14 DOC: or anything [like that.
 15 MOM: [(Okay.)

Also see Extract (12):

(12) 17–08–02

- 1 DOC: -> Uh::m o- nl- unfortunately we prob_ably can't give her
 2 -> stuff .hh like Sudafed.
 3 (.)
 4 DOC: Because that'd crank her blood pressure up-
 5 an' we don't need tha:t.
 6 MOM: Right.
 7 (1.0)

- 8 MOM: -> Okay: so give her Tylenol?=
 9 DOC: =Yeah.
 10 (0.2)
 11 DOC: for discomf_ort.

In this case, after the physician recommends against an over-the-counter cold medication (lines 1–2), the mother inquires about another form of non-prescription treatment that she could offer her daughter (line 8), and the doctor agrees to this (lines 9–11).

Parent responses to alternative treatment recommendation formats

Parents' responses to treatment recommendations vary depending on whether the recommendation is formatted as *for* or *against* treatment. Whereas parents are more likely to accept positive announcements of treatment recommendations, resistance is more likely to be engendered by a recommendation against a particular treatment. For instance, note that two of the more extreme active resistance examples shown earlier both involved an initial recommendation against antibiotics – Extracts (5) and (7a)–(7f). In particular, return to Extract (5). Here, although the physician may have intended to go on to offer affirmative action steps, once a ruled-out treatment recommendation was on the table in line 4 the parent's acceptance was due in line 5. Instead, passive (line 5) and then active resistance (beginning in line 6 and extending through to line 27) must be managed before an affirmative action step can be proposed. I argue that the root of this issue is the lack of an affirmative and specific treatment recommendation. This becomes even more visible as the root issue in cases where no treatment is offered, as in Extract (13). Here, the physician implies a recommendation against any medication through her diagnosis of a cold and her statement that the mother does not “have to be so concerned about it” (data not shown). The mother's response is a type of active resistance: she states her concern that the illness may get worse over the long weekend ahead (lines 1–2 and 4).

(13) 15–06–04

- 1 MOM: -> I just was worried with thuh Thank- thuh long
 2 -> weekend ahead of us I wasn't su[re if he was=

- 3 DOC: [Yeah:-
 4 MOM: -> =gonna get worse [or no:t.
 5 DOC: [Yeah:.
 6 DOC: .hh No I:- I:- (.) I'm [thinking he p'obably=
 7 MOM: [Okay.
 8 DOC: =gonna get better.
 9 DOC: .h but he pro'ly s- gonna still have uh cou:gh,
 10 MOM: O[kay:.
 11 DOC: [Or uh runny no:se. but I don't think he should-
 12 be having uh fever anymo:re.
 13 DOC: .hh unless: he start developi:ng <other: kinda
 14 infections> like uh pneumo:nia or uh sinus infection
 15 .hh things like that.=
 16 MOM: =If: his fever continues thuh next few day:s?,
 17 DOC: Mm hm:, I would bring him back Monday.
 18 (0.8)
 19 MOM: But that's like three four days ahead [of me I mean=
 20 BOY: [Mommy
 21 MOM: =do I stick it ou:t?, or [do I call an' will somebody=
 22 BOY: [Mommy:
 23 MOM: =prescribe [an' antibiotics [or something?,]
 24 DOC: [Oh ye^ah. [hh If you ca:ll,
 25 DOC: they might not
 26 BOY: (Mommy [)
 27 MOM: [Give him any[thing
 28 DOC: [You may- They may not give you
 29 (many) a- anything.
 30 DOC: .h any antibioti:cs.
 31 DOC: It(s) just depend on how high the fever is.
 32 MOM: Okay.

The parent's resistance to a no-treatment recommendation in lines 1–2 and 4 makes relevant a statement from the physician about what to do in such a situation. Instead the physician's recommendation is only to return Monday if things worsen. This visit takes place on the Wednesday before the Thanksgiving holiday. Since the office will be closed for the holiday and the Friday following, this recommendation delays the possibility of treatment for five days. In this sense, similar to other no-treatment recommendations (such as recommendations against treatment) this suggestion fails to provide the parent with an affirmative next action step since the plan is too far removed from the current circumstances. This is evidenced by the mother's next round of resistance: "But that's like three four

days ahead of me" (line 19). In particular, the "but" preface of this turn treats what follows as in conflict with the physician's plan to bring him back Monday if the illness persists. She resists further with an inquiry about whether someone will provide her with an affirmative treatment of antibiotics if her child worsens (lines 21 and 23) – a question that overtly lobbies for antibiotics (Stivers 2002a).

The pattern of resistance to recommendations against particular treatment is not uncommon. In Extract (14), following the physician's recommendation against treatment in lines 1–2, the mother requests confirmation of what she takes to be the upshot of the physician's recommendation: a recommendation against antibiotics – "so no antibiotics." (line 3). Like Extract (13), this form of resistance is particularly strong because it explicitly questions the physician's no treatment proposal (see Stivers [2002a] for a full discussion).

(14) 15–12–01

- 1 DOC: (Now there's) no- particular treatment that's
 2 neces[sary.
 3 MOM: -> [(intres-) so no antibioti:cs.
 4 DOC: (uhm-) No no.
 5 (.)
 6 DOC: Nuh nuh nuh no. That would make (diarrhea) worse.
 7 MOM: U(h)h h(h)uh.

The physician not only confirms the negative implication (line 4), but after a micropause (line 5) he treats her lobbying for antibiotics as unnecessarily persisting in a course of action with the repeat of "no" (first in line 4 and then more strongly in line 6) (Stivers 2004). Similar to the physician in Extract (7) who denied the mother's request, here too the physician offers an account for his rejection of the parent.

Relying on interactional evidence, we have seen that treatment recommendations that are delivered negatively are more likely to engender resistance. We can now examine this and associated patterns in the pediatric data quantitatively.

Distributional evidence. Table 10.1 shows the bi-variate relationship between treatment recommendation format and parent resistance restricted to cases where antibiotics were neither prescribed nor given as an in-office injection. In particular, cases were coded as

Table 10.1 *Treatment format by parent resistance*

	No resistance	Parent resistance	Total
No recommendation "against"	95.1% (n = 349)	4.9% (n = 18)	367
Recommendation "against"	82.8% (n = 24)	17.2% (n = 5)	29
Totals	373	23	396
p = .02			

having a recommendation against a treatment if the initial treatment recommendation included this format, and resistance was coded as present only if the parent actively resisted the initial treatment recommendation. As can be seen in Table 10.1, parents were significantly more likely to resist the treatment recommendation if it was presented using "recommendation against" format than if it was presented without such a format (17 percent versus less than 5 percent $p = .02$ single-tailed Fisher's exact test). This evidence further suggests that resistance is typically minimized following recommendations for particular treatment.

Securing parent acceptance. Physicians generally treat prescription medication as desired by patients. One type of evidence for this is that such medication is generally presented using a "recommendation for" format when it is recommended (e.g., pain relievers or antibiotics). An interactional dilemma is posed when physicians do not plan to offer prescription medication – or if they are not providing the most desired of medications. It is this environment which provides a solid context to examine how delivering a less than optimal (from a parent perspective) treatment can be made most palatable. It appears that an initial recommendation for treatment (whether or not a subsequent recommendation against a particular treatment is delivered) offers the best chance of securing parent acceptance because it offers the parent a concrete way to solve or at least address the medical problem. This is in accord with the evidence so far presented.

Extract (15) shows an example of a physician presenting a non-antibiotic treatment using an affirmative format. Following a diagnosis of a cold (line 1) and the explication of the evidence for that diagnosis (lines 2–7), the physician goes on to affirmatively

recommend treatment: cough medicine (lines 8–10 and 13–14), and this is non-antibiotic.

(15) 15–06–14

- 1 DOC: Looks like he has a cold,=h
 2 DOC: It's just uh virus, not uh bacteria;=his lungs sound
 3 really good,=it's just .h all irritation up here;=
 4 =(and)/(that) he's coughing tuh- .h throat looks
 5 uh little red. but there's no puss or anything;
 6 DOC: .hh ear is just uh little (.) slightly pink and .h
 7 it's uh combination for with thuh stuffy nose.
 8 -> .hh so=w:e have=to .h clear thuh nose.
 9 DOC: -> Ya know like ((exhaling noise))/(0.2)
 10 -> reduce thuh congestions that will help him uh lot.
 11 DOC: [.hh
 12 DAD: [>Mm hm;<=
 13 DOC: -> =An' I'm gonna give you some cough medicine that has
 14 -> some decongestant in it.
 15 BOY: ((whispering))/(DAD nods)
 16 DAD: => Mokay.

The physician suggests a type of cough medicine (lines 13–14). This is accepted both visibly (line 15) and vocally (line 16). In these situations, the cough medicine may or may not turn out to be prescription, but what appears to be important in whether or not resistance is likely to be engendered is that a specific recommendation for action has been made. Although the cough medicine is not named, the physician states that she is going to "give you some" (line 13) and specifies that it has "some decongestant in it" (line 14). Both of these aspects of the turn indicate that she has in mind a particular medication and in this way she is being specific in her recommendation.

In cases like this, the physician delivers the treatment recommendation in a way which satisfies the conditions outlined earlier for a sufficient treatment recommendation – they are affirmative, specific, non-minimized treatment recommendations. Because recommendations for treatment by definition satisfy the criteria of being affirmative, this may explain why they are less likely to be resisted generally. When recommendations for treatment are resisted, they typically fail on one of the latter two dimensions. That is, they typically either involve a vague/non-specific treatment recommendation

or the physician minimizes either or both the child's diagnosis and the treatment recommendation. In Extract (16), the physician has recommended against antibiotics and, with no parent uptake, has affirmatively suggested using "whatever your favorite cough medicine is," (lines 4–5). He has further downgraded the recommendation with the TCU-initial "Simply" (line 4), which depicts the treatment as elementary.

(16) 17–08–12

- 1 DOC: -> As you know they're viral infections, so there's
 2 -> no point in any a- any ant- antibiotics.
 3 (0.5)
 4 DOC: -> Simply control thuh cou:gh with .hh whatever
 5 -> your favorite cou:gh medicine is,
 6 (1.8)
 7 DOC: #hmg hmg#=#h[h
 8 DAD: => [That's what I figured. (0.5) it
 9 => was her mo:m who called.
 10 DAD: => I said you got (tuh be k(h)idd(h)ing) he's probably-
 11 => .hh heard about: couple hundred cases already=
 12 => =there's not much he's gonna be able to do: so-
 13 DOC: .hh (only make her uh little) more comfortable of course.
 14 DAD: Yeah:h,
 15 DOC: You take your=uhm (0.8) #uh:m# (0.8) Tylenol for thuh
 16 discomfort_ .hh Now #hmh#=#hhh (1.0) ° °
 17 (1.0)
 18 DOC: There's- (0.5) Triaminicol has uh new thing out-
 19 (1.0) there's uh Triaminicol soft chews they're
 20 called, (11.5)
 21 DOC: Uh:m they taste goo:d, 'n they c'n chew them up.
 22 DOC: It's got uh cou:gh suppressant, thuh nose dryer upper-
 23 DAD: Yeah, (o[kay.)
 24 DOC: [which'(ll) make 'er feel better;

The parent responds by first claiming his own expertise (line 8) and then placing blame on the child's mother for the medical visit (lines 8–12). By retroactively casting the child's mother's concerns as unnecessary, he displays his own understanding that the legitimacy of this visit has been threatened. The physician takes up this dimension of the father's utterance stating that he can offer expertise for making her "more comfortable" (line 13), and goes on to affirmatively suggest specific treatment of Tylenol and Triaminicol.

Treatment recommendation formats: implications for health care practitioners

The previous section shows that practitioners who format their treatment recommendations as *against* treatment are more likely to encounter resistance. Thus, one communication option would be for physicians to recommend treatment positively, never recommending against treatments. If negatively formatted treatment recommendations are more likely to engender parent resistance, an argument might be made that there is no reason for physicians to use them at all. However, at least in the case of antibiotics, prior research suggests that physicians are more likely to recommend against antibiotics following particular parent behaviors (e.g., after offering a bacterial candidate diagnosis) that indicate they are seeking antibiotics (Stivers 2002b). In such contexts, recommending against antibiotics appears to be designed as an interactionally responsive, and thus potentially validating, behavior.³

A second purpose of recommendations against particular treatment is parent education. When ruling out the need for a potentially desirable medication like antibiotics, physicians very often provide an account for this recommendation – see Extracts (5), (7), (12), (14), and (16). In doing so, physicians at the very least convey that they considered prescribing it and decided against it – something that may reassure parents who were concerned about the necessity of the medication. In some cases, following a recommendation against particular treatment, physicians go on to explain why they are not prescribing the drug. When this is done prior to an affirmative and specific treatment proposal, the educational dimension is likely to be lost – see Extract (5). However, when it is done subsequent to an affirmative and specific recommendation, such as Extract (17), it can work not only to provide education but also to solidify acceptance of the proposal. Note that the parent is resisting the treatment that is proposed. She offers only provisional acceptance with her nod in line 12. It is in this environment that the physician recommends against antibiotics and offers an account for this. This is successful

³ Note that I do not mean that a physician who denies a parent's candidate diagnoses is validating him or her. However, when a parent has stated a concern about a particular condition, when a physician recommends against the treatment for that condition, this at least conveys that the physician considered the treatment. It is in this sense that the physician validates the parent's concern.

at least insofar as the mother inquires about one of the treatments, thereby taking it seriously.

(17) 30-26-01

- 1 DOC: (I'll) control it with (.) #uh::# motrin (or fe-) for
 2 high fever?,
 3 -> (0.5)
 4 DOC: Tylenol,
 5 -> (0.6)
 6 DOC: Lots of fluids, (.) rest,
 7 -> (0.5)
 8 DOC: an:d (.) cough an' cold medicine.
 9 -> (1.0)
 10 DOC: => That's all:
 11 -> (0.2)
 12 MOM: ((nods))
 13 DOC: => Okay?,
 14 (0.2)
 15 DOC: => There's no need for antibiotic; (this is like) viru(s).
 16 (0.5)
 17 DOC: => Sometimes gets worse with thuh antibiotic.
 18 (.)
 19 MOM: So thuh main thing is just thuh liquids.

Accordingly, recommendations against particular treatment are not to be discounted entirely, since they provide physicians with a resource for communicating two important matters: that their treatment recommendations for the patient's problems are responsive to their/the parent's concerns of whether a particular medication was necessary; and education about when a potentially desirable medication like antibiotics may not be appropriate. But they are best done following an affirmative and specific treatment recommendation.

Discussion

This chapter has shown that, contrary to what might be expected, the treatment recommendation phase of acute medical encounters requires parent participation. That is, following physicians' treatment recommendations, both parents and physicians have been shown to treat parents as having the right and the responsibility to accept the treatment recommendation offered by the physician regardless of whether that recommendation is explicitly formatted

to invite their participation or not. When parents do not accept the physician's recommendation, physicians pursued such acceptance even to the point of offering (sometimes major) concessions and inappropriate prescriptions. In the last sections of this chapter, I argued that physicians who offer their initial treatment recommendation as *against* a particular treatment are more likely to be met with parent resistance. This was observed to be part of a larger pattern of behavior which suggests that parents orient to treatment recommendations as sufficient only if they include an affirmative and specific next action step.

As mentioned early in this chapter, the data were diverse – internal medicine, orthopedics, and pediatrics. The fullest analysis was done with a large corpus of acute pediatric encounters. However, the practices involved in negotiating treatment appear to be present in the adult context(s) as well. That said, it may be the case that children are nonetheless special insofar as they are oriented to by physicians and parents as a shared responsibility. The two “care-givers” may, however, have competing goals. The physician may see not putting the child on medication as better for the community and for the child in the long run, insofar as most of these cases involved a decision of whether or not to prescribe antibiotics. The parent may see putting the child on medication as important for making the child feel better in the here-and-now because he or she is responsible for attending to the child when he or she wakes up during the night or is in pain. Therefore, the process of negotiation, though present in both adult and pediatric contexts, may be particularly salient in pediatrics.

An implication of this chapter for practitioners is that parents are already participating in decisions about their treatment even if they are not being overtly invited to do so. Practitioners report feeling pressured by parents for certain types of treatment and sometimes to prescribe inappropriately, and normally assume this behavior to be overt (Barden et al. 1998; Palmer and Bauchner 1997; Schwartz 1999; Schwartz et al. 1997). In fact, most parental pressure (at least in the US context) appears to be covert or tacit such as the resistance types discussed here (Stivers 2002a). Both passive and active resistance affect physician behavior even to the extent of altering what physicians prescribe. Therefore, minimizing resistance is an important strategy for physicians. One mechanism for

minimizing resistance (and consequently inappropriate prescribing) is to offer patients/parents a concrete next action step as an initial treatment recommendation (even if this is not medication). This provides patients/parents with a solution to their medical problem and may help to legitimize their having sought medical help in the first instance (Stivers 2005a).

This chapter contributes not only to our understanding of how patient participation can affect treatment outcomes but also to our understanding of what patient participation is. Through this chapter I hope to have made a case that in both the health care research and the practitioner communities, we should broaden our conception of patient participation. This chapter also offers a cautionary note with respect to patient participation. While current research celebrates the many benefits of patient participation, the potential costs have been less well documented. This chapter suggests that, although patient participation is certainly important (and, moreover, patients are participating currently anyway), in certain contexts their participation may involve pressure for outcomes that are detrimental either to themselves or to the larger society. Therefore, patient participation should be actively encouraged, but practitioners should also be educated about both eliciting this participation and recognizing more passive and implicit forms of participation in order to determine how best to deal with pressure for inappropriate and risky forms of treatment.