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Parent Resistance to Physicians' Treatment Recommendations: One Resource for Initiating a Negotiation of the Treatment Decision

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Parent Resistance to Physicians’ Treatment Recommendations: One Resource for Initiating a Negotiation of the Treatment Decision

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This article examines pediatrician–parent interaction in the context of acute pediatric encounters for children with upper respiratory infections. Parents and physicians orient to treatment recommendations as normatively requiring parent acceptance for physicians to close the activity. Through acceptance, withholding of acceptance, or active resistance, parents have resources with which to negotiate for a treatment outcome that is in line with their own wants. This article offers evidence that even in acute care, shared decision making not only occurs but, through normative constraints, is mandated for parents and physicians to reach accord in the treatment decision.

This article focuses on physician–parent interaction surrounding the activity of treatment recommendation and discussion. In particular, I concentrate on cases involving children with upper respiratory infections (URIs). This context is important because, in most cases, the physician is working to determine whether the child has a bacterial infection, which would be treatable with antibiotics, or a viral infection, for which antibiotics would be inappropriate and only symptomatic treatment is helpful. Although the United States, along with many other developed nations, faces a large-scale problem with antibiotic-resistant bacteria (e.g., Baquero, Baquero-Artigao, Canton, & Garcia-Rey, 2002; McCaig & Hughes, 1995; Neu, 1992; Whitney et al., 2000; Wise et al., 1998), inappropriate prescribing of antibiotics for viral infections remains common (e.g., Finkelstein et al.,

2000; Gonzales, Malone, Maselli, & Sande, 2001; Mainous, Hueston, & Clark, 1996; Mangione-Smith et al., 2003; McCaig, Besser, & Hughes, 2002). Inappropriate use of antibiotics has led to rapidly increasing risks of resistance among many strains of bacteria that commonly infect children and adults (Cristino, 1999; Deeks et al., 1999; Gomez et al., 1995; Nava et al., 1994; Watanabe et al., 2000). Resistant infections pose a risk not only to the individual but to the community because those infections are more difficult to treat (Dagan, 2000; Friedland, 1995; Watanabe et al., 2000), are more costly (Gums, 2002; Holmberg, Solomon, & Blake, 1987), and result in increased mortality (Feikin et al., 2000). For all of these reasons, researchers and policy makers strongly advocate for more judicious prescribing practices (e.g., Bell, 2002; Belongia et al., 2001).

Heavy, and in particular inappropriate, antibiotic prescribing occurs frequently in pediatrics because the most common illnesses are routine URIs such as colds; flu; and throat, ear, or sinus infections. Sixty-five percent to 70% of these infections are viral and thus can not be effectively treated with antibiotics (Kaiser et al., 1996; Orr, Scherer, MacDonald, & Moffatt, 1993; Todd, 1984), but current research shows that 30% of pediatric patients with colds receive antibiotics (Gonzales et al., 2001). Gonzales et al. estimate that the prescribing rate for bronchitis and other illnesses that are typically of viral origin is as high as 60%. Furthermore, research indicates that between 48% to 65% of parents visiting report an expectation that their child will be given antibiotics (Hamm, Hicks, & Bembem, 1996; Mangione-Smith et al., 2003; Mangione-Smith, McGlynn, Elliott, Krogstad, & Brook, 1999; Sanchez-Menegay & Stalder, 1994). In addition, results from the National Ambulatory Medical Care Survey (Aronoff, 1996) suggest that children receive two to three times more antibiotic prescriptions than any other patient group, including the elderly. Thus, overuse in the pediatric population poses the greatest risk to the community as a whole.

The question of why physicians continue to overprescribe antibiotics in the face of the antibiotic-resistance problem appears to be strongly related to patients' and parents' pressure on doctors for a quick solution to their problem. Physicians commonly cite parent pressure as a reason for prescribing (Barden, Dowell, Schwartz, & Lackey, 1998; Palmer & Bauchner, 1997; B. Schwartz, 1999; R. H. Schwartz, Freij, Ziai, & Sheridan, 1997). In addition, researchers in both the adult and pediatric contexts found that doctors' perceptions of patients' expectations for antibiotics had a significant effect on whether the doctor prescribes antibiotics even in cases in which the doctor judged them to be not indicated (Britten & Ukoumunne, 1997; Cockburn & Pit, 1997; Gani et al., 1991; Hamm et al., 1996; Mangione-Smith et al., 2003; Mangione-Smith et al., 1999; Vinson & Lutz, 1993). Interactional practices used by parents are associated with perceptions of parent expectations for antibiotics and appear to be what actually constitutes "pressure" (Stivers, 2002a, 2002b; Stivers, Mangione-Smith, Elliott, McDonald, & Heritage, 2003). In this study, I focus on one such practice illustrating that parent resistance to a physi-

cian's nonantibiotic treatment decision initiates a negotiation of the treatment recommendation. I show that this practice accomplishes this action through an existing orientation to treatment recommendations as proposals that normatively require parent acceptance before physicians can complete the activity of treatment recommendation. Seen in this way, parents may be understood as participating in their children's treatment decisions through their responses to physicians' treatment proposals.

This article first examines the types of responses that parents give to treatment recommendations, building the case that parents display that they have rights to accept the proposed treatment recommendation or not. Second, I demonstrate that, in the absence of parent acceptance, both physicians and parents display that mutual agreement is required before the activity of treatment recommendation can progress to closure. Such consensus emerges in two ways: (a) physicians pursue parent acceptance and (b) parents shift from passive to active displays of disalignment with the treatment recommendation. Third, I show that, insofar as parent acceptance is required as a condition of closing the treatment recommendation activity, parent resistance can lead to concessions and modifications of the physician's treatment recommendation. Finally, implications of this study for issues of parent and patient participation are discussed.

DATA AND METHOD

The analyses presented here are based on two primary data sets involving a total of 360 audio- and videotaped acute care pediatric encounters with a total of 14 pediatricians—9 community practice (6 were men and 3 were women), and 5 university based (all of whom were women). All pediatricians worked full time and were recruited either in person or by telephone.

All visits were collected between September 1996 and June 1997. In addition, several examples for this article have been taken from an additional data set collected during October 2000 to June 2001 involving community practice physicians. Preliminary analyses of this data set suggest that the behaviors previously identified operate in the same ways in the new corpus. Thus, two instances presented in this article are from that data set. Informed written consent was obtained from all participating parents and physicians, and the University of California Los Angeles Institutional Review Board approved all study procedures. For purposes of anonymity, pseudonyms replaced any use of a participant's name or other identifying information (e.g., school names).

Conversation analysis (CA) was used as a method for analyzing the audio- and videotaped data (see Heritage, 1984, for summary). As summarized in earlier work on these data (Stivers, 2002a, 2002b), CA examines the social actions that interactants accomplish in and through interaction (e.g., greetings, requests, invita-

tions) focusing on sequences of interaction rather than restricting analyses to isolated sentences or phrases. In examining social interaction, CA looks for patterns in the interaction that form evidence of systematic usage that can be identified as a “practice” through which people accomplish a particular social action either vocally or nonvocally. To be identified as a practice, a particular communication behavior must be seen to be recurrent and to be routinely treated by a recipient in a particular way such that it can be discriminated from related or similar practices. In so doing, analysts’ understandings of participants’ social actions can be validated through an examination of interactants’ responses.

Utilizing CA as a primary methodology, this study examines physician–parent encounters in detail to observe, from a qualitative perspective, the resources physicians and parents use to negotiate a decision of whether or not to prescribe antibiotics for a child with upper respiratory symptoms. In line with this methodology, the data were transcribed according to the conventions originally developed by Gail Jefferson (see the Appendix for conventions). The cases that are discussed were selected because they represent especially clear examples of the phenomena. In addition, as a qualitative study, precise frequencies are not provided, but an effort is made to describe the relative frequency of the practice or range of practices. All claims about the relative frequency of given communication practices are for these data, unless otherwise stated.

ANALYSIS

Parent Responses to Treatment Recommendations

In what follows, I suggest that treatment recommendations are oriented to by participants as proposals that normatively require acceptance for the physician to progress to the next phase of the visit—closing the encounter (see Byrne & Long, 1976; Robinson, 2003; Waitzkin, 1991, for a discussion of acute medical encounter activity structure). One type of evidence for this argument is the way that parents respond to treatment recommendations. This is particularly striking when parent responses to treatment recommendations are compared with their responses to diagnosis deliveries. Broadly, the two activities—diagnosis delivery and treatment recommendation—involve the physician imparting medical knowledge to the parent. For this reason, it might be expected that they would be acknowledged by parents in rather similar ways. However, this is not the case. Instead, parents and physicians alike orient to diagnoses as within the physician’s domain of expertise. Diagnoses are routinely not accepted and often are not responded to even minimally (Heath, 1992; Peräkylä, 1998). Physicians also do not pursue parent uptake of their diagnoses. By contrast, treatment recommendations are typically accepted by parents, and acceptance is, as shown in later sections, oriented to as relevant. In this way, parents and physicians treat

parents as having the right to accept or reject the treatment proposal. For example, see Extract 1.

(1) 2002 (Dr. 6)

1 DOC: .hhh Uh:m his- #-# lef:t:=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 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, when the physician offers her treatment recommendation in line 6 the father accepts this with “Alright.” immediately on possible completion of that turn constructional unit.¹

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 is that she
 2 ha:s 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.

By contrast, 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.² The use of these two receipt tokens in such close proximity offers evidence that parents orient to diagnoses and treatment recommendations as actions that make relevant different sorts of responses.

Parents not only respond to treatment recommendations regularly but they also display their rights to accept these recommendations through their turn design. For example, see Extract 3. Here, the parent's ultimate acceptance of the

¹This is particularly notable because the intonation at the end of line 6 is very similar to that of line 1.

²Although this claim requires more investigation, it appears that period intoned “Okay”s and “Alright”s are treated as accepting, whereas these objects said with comma or level intonation may be offering only acknowledgment. Beach (2001) has explored prosodic variation in the token “okay.”

treatment recommendation is a full-form agreement “Let’s do that.” (line 15). At line 1, the doctor offers his findings during the chest examination of the child as “uh little congested in his che:st,” and appears to be moving into the final diagnosis of the patient with “Yeah I think-” (line 2). At this point, the mother takes issue with the physician’s mitigation of “congested” and asks a question about her son’s more severe morning congestion (lines 5 and 7). When the physician moves to his treatment recommendation (line 11), the recommendation is offered in an unequivocal manner with “we hafta”; however, the mother nonetheless displays her orientation to it as a proposal to be accepted or rejected by accepting it in line 15 with “Let’s do that.”

- (3) 1120 (Dr. 1)
- 1 DOC: Well he sounds uh little congested in his che:st,
 2 DOC: Yeah I [think-
 3 MOM: [Now it’s little:.
 4 DOC: [Yea:h.
 5 MOM: [.hh But why is it that- in thuh [morning=
 6 BOY: [#HUH huh#
 7 MOM: =it’s just [so:-
 8 DOC: [Well that’s because a:ll drips down
 9 the back of his throat,
 10 MOM: Uhhh ((sigh))/(0.2)
 11 DOC: I think we hafta put him on >an antibiotic<.
 12 #Eh: he just has- with his ea:r,
 13 BOY: Duh!
 14 DOC: an’ he has like a bronchitis in his chest,
 15 MOM: -> Let’s do that.
 16 DOC: Bu:t=he’ll be fi:ne.=h

As noted previously, the mother’s formulation “Let’s do that.” is stronger than “Okay.” or “Alright.” “Let’s” explicitly treats her child’s treatment as a shared decision. Although acknowledgment tokens such as “Okay.” and “Alright.” perform acceptance of the treatment (Heritage & Sefi, 1992), the design of acceptance turns provides evidence that parents orient to the relevance of their stance with respect to treatment recommendations. Notably, the parent does not acknowledge the diagnoses of an ear infection (noted earlier and indexed here with “with his ea:r”) and bronchitis despite their being just prior to the parent’s turn. In fact, her response “Let’s do that.” addresses only the action of putting him on antibiotics.³

This section showed that, through their turn designs, parents explicitly accept treatment recommendations rather than merely acknowledging them. In this way, parents claim that they have rights to accept the proposal. Although sometimes diagnostic evaluations are acknowledged with “Okay.”, they are not routinely treated

³The placement of the treatment recommendation prior to the diagnosis may help to avoid further sequences of parent resistance.

as proposals for acceptance or rejection. Thus, neither resistance nor acceptance of the diagnosis is typical. Conversely, treatment recommendations are routinely accepted with objects such as period intoned "Okay." or "Alright.," "Let's do that.," "That's fine.," and assessments such as "Good."⁴

Parents' Withholdings of Acceptance

The previous section showed that parents oriented to having rights to accept the physician's treatment recommendation or not. In this section, I argue that physicians and parents share a normative orientation to parent acceptance of the treatment recommendation. I show this orientation, first, through the ways in which physicians pursue parents' withholdings of acceptance and, second, through the ways that parents upgrade their resistance from withholdings of acceptance to active resistance.

If there is a normative constraint that makes parent acceptance of the treatment proposal relevant, then, in addition to active disalignment to the proposal, passive withholding of acceptance will hearably constitute resistance to the proposed treatment. Passive resistance was found by Heritage and Sefi (1992) in the context of community nurse visits to first-time mothers. They showed that such resistance to health visitor advice involved "unmarked acknowledgments" such as "mm hm", or "yeah". These objects, they argue, "do not acknowledge or accept that talk as advice" and thus "do not constitute an undertaking to follow the advice offered" (p. 395). In my data, there is an orientation to silence and unmarked acknowledgments as similarly withholding acceptance of the proposed treatment. First, when parent acceptance is not forthcoming following a physician's treatment recommendation (i.e., passive resistance), physicians typically pursue the parent's acceptance,⁵ treating it as noticeably absent, and furthermore, they do not move out of treatment recommendation (i.e., they do not initiate activity closure). These behaviors offer evidence that physicians orient to parent acceptance as normatively required.

Pursuit of parent acceptance takes several formats, including offering a rationale for the treatment recommendation, offering evidence for the underlying diagnosis, returning to the examination findings, and offering the parent a concessionary future action. An example is shown in 4a.

(4a) 2043 (Dr. 8)

- 1 DOC: (Is) it's not infect:e:d, [There's- uhm no fluid or=
 2 MOM: [Mm.
 3 DOC: =anything,

⁴Period intoned "Okay." or "Alright." appear to be more minimal forms of acceptance. It may be that fuller forms of acceptance are treated as optimal in this environment and therefore lead most directly to activity closure.

⁵For a general discussion of pursuit of agreement, see Pomerantz (1984b).

- 4 DOC: .hh An' his lungs are completely clea:r_ Uhm_
 5 (0.5) An' he's not- breathing very fa:st, or har:d,
 6 DOC: Uhm_ .mlkh So I think he's just on his road to
 7 recovery:_ he just needs: another_ .h prob'ly another
 8 week or so to get rid of thuh cou:gh completely,
 9 MOM: -> (°Mm hm, °)
 10 DOC: => Just lots of=flui:ds,
 11 DOC: Uhm he was prob'ly uh little bit dizzy cuz he was:-
 12 °he had fever and he prob'ly hadn't drank enough
 13 => at thuh ti:me, prob'ly.°
 14 DOC: => .h Uh:m_ .h So lots to dri::nk,
 15 DOC: and then uhm .mlk if he gets- - fever agai:n,
 16 (0.2) thou:gh uhm .h in thuh next two or three
 17 => day:s, .h uhm_ (0.2) we may need to see him ba:ck,
 18 DOC: in case he-n- does come down with something secondarily,

In line 1, the doctor offers a diagnostic evaluation that continues across lines 3 to 5. The parent minimally acknowledges this in line 2. At line 7, the doctor begins to detail her treatment recommendation—doing nothing for another week. The parent again offers only a minimal acknowledgment (line 9). In response, the physician expands her treatment recommendation, adding a second recommendation of fluids. In contrast to her first recommendation, this proposal is of something the parent can *do* (for a discussion of this, please see Stivers, 2005). That this is designed as an expansion is evidenced with the reuse of the “just x” formulation used initially in line 7. Here too, the mother withholds acceptance. The physician next offers an account (lines 11–13) for some of the symptoms the parent reported as problematic. This account supports her treatment recommendation to offer fluids (line 10) by proposing that the symptom was the result of dehydration. The mother again passes on an opportunity to accept the proposal, and the physician here pursues agreement by restating her treatment recommendation with “So lots to dri::nk,” (line 14). Redoing the treatment recommendation overtly renews the relevance of parent acceptance. When acceptance, once again, is not forthcoming, the physician slightly modifies her proposal. Here, she suggests what the parent can do if the child fails to improve—the parent can bring the child back (line 17). Finally, in line 18 after the parent has, once again, passed on the opportunity to respond, the physician concedes that the boy may need different treatment in the future if he should “come down with something secondarily.” Each of the physician’s moves works to elicit parent acceptance of the existing treatment recommendation and thus displays the physician’s orientation to the relevance of parent acceptance.

A similar case is shown in Extract 5. Here, the father withholds acceptance of the physician’s recommendation to just “watch i:t”.⁶

⁶Here and in later examples, I do not have access to video to determine if there is was visible behavior during these silences. However, as shown particularly in the next section, if there were any visible behavior occurring during these spaces, the physicians do not treat it as sufficient to accept the recommendation.

(5a) P201 (Dr. 7)

- 1 DOC: Unfortunately like most viruses we have to watch i:t?
 2 DOC: -> .hh becau:se- you know- she (can)/(could) have uh fever::
 3 for another few days, and nothin' el:se.
 4 -> (.)
 5 DOC: and jus- an' be fi:ne,
 6 DOC: .hh Or else if she got uh fever an' got wor:se,
 7 and: started limping actually at that time we'd
 8 probably need 'er tuh come ba:ck,
 9 DOC: -> .hh But at this moment since there's no swelli:ng?,
 10 or there's no: .hh you know <nothing el:se,
 11 th-uh most important thing
 12 t' do is tuh watch her.
 13 DOC: -> .hh So we've had a few people right no:w that have had-
 14 uh few of our kids are having tlk .h fever:s, for a few
 15 days, and not much other symptom:s.
 16 DAD: So can she go to preschool now?

In this extract the physician has explained to the father that his daughter has a viral infection. In line 1, she suggests that the best course of action is “to watch i:t?”. The father neither acknowledges nor accepts this recommendation despite even the rising intonation. The physician expands her recommendation in lines 2–3 with an account that the girl could easily have no other symptoms. The father does not accept this either (line 4). The physician here shifts to a discussion of a future plan. Similar to the doctor in Extract 4a, line 17, here in lines 6–8, the physician suggests when the parent could reasonably return for another medical evaluation. Here too, the father withholds acceptance. In lines 9–10, the physician returns to her previous physical examination findings as further support for her diagnosis. Typically, when physicians retreat to previous activities, including restarting a verbal or physical examination or restating diagnostic findings, they then proceed again through the remaining activity phases back to treatment recommendation. This action occurs here too. Having retreated to diagnostic findings, the physician next restates her treatment recommendation to watch and see (lines 11–12). By restating the treatment recommendation, the physician—similar to the physician in Extract 4a—more overtly renews the relevance of the father’s acceptance. However, here too, none is forthcoming. In lines 13–15 the physician offers a more generic rationale for her diagnosis—that several other children are having similar symptoms. Still, there is no acceptance from the father, although he initiates another sequence with a question about whether the girl can return to school.

Extract 6 shows similar behavior by the parent, in the sense of passing on opportunities to accept. However, in this case, the physician pursues acceptance much more aggressively. At this point in the visit, the physician has just completed a throat culture that will take several minutes to display the result. She begins her treatment recommendation with suggestions that are irrespective of the pending culture. Similar to Extracts 4a and 5a, 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 no case does the parent offer acknowledgment, let alone acceptance.

(6) 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 throa:t, 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 => Mkay,

16 DOC: -> .h That clears it out an' that makes it feel better.

17 Mkay,=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 tha:t,

21 DOC: => hh Give 'er uh soft die:t?, Mkay:, 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

30 drink.=h

31 DOC: -> Ice cream is okay:, That will make her feel better:,

32 DOC: -> .h Popsicles,

33 (.)

34 DOC: -> That makes you feel better,

35 DOC: => .h Mkay:?,

36 DOC: -> .h Maybe some mashed potatoe::s, you know

37 -> (so)/(it's uh) soft diet. as uh general.

38 (.)

39 DOC: => Yogur:t, things like that. Nkay:,

40 DOC: -> .hh Uh:m_ and you're just gonna have to rest.

41 (.)

42 DOC: You know?,

43 (.)

44 DOC: She's gonna have to rest.

45 MOM: Yeah.=

46 DOC: =No more running arou:nd an'- (.) ya know staying

47 -> up la:te, an' things like that.
 48 DOC: .h You're just gonna have=t' take lots of na:ps,
 49 -> an' re:st, throughout thuh weekend.
 50 DOC: => .h Mkey:, ((Doc moves to look at rapid strep culture))

This physician seeks acceptance of her treatment recommendation not only in ways shown in extracts 4a and 5a with, for instance, accounts for her recommendation (e.g., lines 16 and 31) and restating her recommendation (e.g., lines 10–11), but also more overtly through intonation, explicit requests for acceptance, and lists. She pursues acceptance with rising intonation at the end of TCUs such as in lines 8, 9, and 21 (Sacks & Schegloff, 1979; Schegloff, 1996). That these locations were designed in pursuit of acknowledgment can be seen, for example, in the doctor's repeat of lines 8 and 9 in line 10 and the despecification with "All the way back." also in line 10. There is still further pursuit in line 11, first with the demonstration of gargling, 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 her use of three-part lists, the physician also hearably invites the parent's uptake. For example, at the end of line 19, the doctor reaches the third item of her projected three-part list and thus seeks confirmation.⁷ The three-part list is a format that is strongly designed for recipient uptake (Heritage & Greatbatch, 1986; Jefferson, 1990). A similar list can also be seen in lines 29–30, but, again, the parent does not offer any uptake.

In addition, the physician actively pursues the parent's acceptance at a variety of points. For example, in the double-arrowed lines, the doctor can be seen to pursue acceptance with various forms of "okay". In line 42, the physician pursues a response with "You know?.". However, it is not until line 45, after multiple pursuits and changes in address from "you" to "her", that the mother offers a minimal agreement with the doctor's treatment recommendation of rest.

This section has shown that physicians display an orientation to parent acceptance as required before the activity of treatment recommendation can be closed. In addition, physicians' pursuits of acceptance include extending the activity with accounts, returning to prior activities such as diagnostic findings in support of the treatment recommendation, offering possible or actual concessions, or overtly pursuing acceptance with "try-marked" intonation (Sacks & Schegloff, 1979) or with variations on "Okay.". All of these behaviors work to secure parent acceptance of the treatment recommendation.⁸

⁷This three-part list is also pursued with "So let's do that." (line 20).

⁸This is not to say that these behaviors do not perform other actions simultaneously. For instance, many of these expansions also provide the parent with additional information about their child's illness and/or the rationale behind the physician's recommendation. However, it appears that this is provided contingently in the service of eliciting parent acceptance when it was not initially forthcoming.

Active Resistance

A second piece of evidence that withholding of acceptance constitutes resistance is that parents routinely shift from passive resistance to active resistance. Active resistance includes an action that questions or challenges the physician's treatment recommendation, including proposals of alternative treatments. These actions make relevant a response by physicians and this feature differentiates active resistance from passive resistance. Heritage and Sefi (1992) found that this pattern was present in some of their advice-giving sequences as well. That is, sequences that included unmarked acknowledgments culminated in a "more overt expression of resistance" (p. 402).⁹ An example from the data is shown in Extract 4b. The first component of the treatment recommendation activity was shown in Extract 4a.

Here, following the physician's indication of what sort of symptoms would cause her to review the child's case for treatment (lines 15–18),¹⁰ the parent actively resists the physician's treatment recommendation.

(4b) 2043

- 14 DOC: .h Uh:m_ .h So lots to dri::nk, and then uhm .mlk
 15 if he gets- - fever agai:n, (0.2) thou:gh uhm .h
 16 in thuh next two or three day:s, .h uhm_ (0.2) we
 17 may need to see him ba:ck, in case he-n- does
 18 come down with something sec[ondarily,
 19 MOM: -> [(See c- cuz-) what I
 20 was worried about I [(would've)/(wouldn't)=
 21 DOC: [Mm hm,
 22 MOM: =normally_ (0.9)
 23 DOC: m- Bring [him in,
 24 MOM: [interpreted [this as a co- ya know=
 25 DOC: [Mm hm,
 26 MOM: =uh thing that [would run its course but- (.) this=
 27 DOC: [Mm hm?,
 28 MOM: =guy had thuh same thing and wound up on antibiotics
 29 cuz he got an infection.
 30 MOM: .hh[h
 31 DOC: [Whe:[re.
 32 MOM: [How can I prevent that. from happening.

In this example, the mother can be seen to be concerned that her son's condition will become worse and that he will need further treatment if not given treatment

⁹This ordering parallels the larger principle of interaction that conflict-producing turns are typically delayed. Preference organization in response turns displays this principle. There, delays of various sorts precede dispreferred responses, thus allowing the just prior speaker an opportunity to reformulate his or her utterance and thereby remove the relevance of the dispreferred response (Heritage, 1984; Pomerantz, 1984a). A similar pattern is observable with respect to shifts from passive to active treatment resistance.

¹⁰The reference to "something secondarily" indexes the possibility of a bacterial infection that might require antibiotic treatment.

now. This concern is not articulated until the doctor has provided more and more details about her recommendations for future action—understandable as pursuing uptake from the mother. It is only at this juncture that the mother explains “what I was worried about” (lines 19–20). Framed in this way, her turn is formulated as an account—arguably an account for her prior passive resistance. The mother here actively resists the recommended treatment through the juxtaposition of her announcement that her other son is on antibiotics for an infection with her inquiry about how to prevent that from happening to this child. This announcement, and further the inquiry, challenges the physician’s suggested treatment of watchful waiting and fluids.

A similar example is shown in Extract 5b, which follows Extract 5a, shown earlier. Here, the physician is returning to her previous findings, having just responded to a parent question. In line 27, the father shifts from his previous passive resistance to active resistance.

(5b) P201

((8 lines omitted following 5a))

- 25 DOC: She: doesn't have anything right no:w,
 26 any symptoms of mucus or vomiti[ng that's contagious.
 27 DAD: => [Are you gonna give her
 28 ana- antibiotics?
 29 DOC: Yeah- uh No: I don't have anything tuh treat right now
 30 for antibiotics. Her ears look really goo:d, .hh she has
 31 no sign of bacterial infection right no:w?,

Similar to the case shown in Extracts 4a and 4b, the father shifts to active resistance, as shown in line 27–28 with “Are you gonna give her ana- antibiotics?”. Although not required, physicians typically respond not only to the question but treat questions such as this as lobbying for medication. In this way, the father’s question challenges the physician’s own recommendation (for a further discussion of this, see Stivers, 2002a).

The instances shown in this section offer evidence for behavior that is seen pervasively in these data: in the face of an unchanging treatment recommendation, parents systematically progress from withholding acceptance to active resistance. It is this progression that physicians appear oriented to when they work to secure parent acceptance during passive resistance. Thus, both physician and parent behavior provide evidence that there is a normative constraint that parents and physicians must reach agreement regarding the treatment decision before that activity can be closed.

Antibiotic Negotiation

Because of the normative constraint on parent acceptance of the treatment recommendation, a parent’s passive or active resistance of a treatment recommendation

puts the physician in a position of either working to convince a parent to accept the proposed treatment recommendation or offering the parent concessions—either possible or actual. In this way, parent resistance can be seen to be initiating a negotiation of the treatment decision. Through resistance, parents hearably take a position against the treatment they are being offered. In these data, this position is typically against an over-the-counter, nonantibiotic treatment plan. In the following instance, the entry into a negotiation is brought to the surface of the interaction. Here, after the physician offers his position against antibiotics in line 4, the father resists (lines 6/10/12/14/17–18/20/23/25/27).

(7) 32–28-03

1 DOC: I th:ink from what you've told me (0.2) that this is
 2 probably .h uh kind of (0.2) virus infec[ti]on,
 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 insi:st_ 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,

In lines 23/25/27, the father states that antibiotics solved his own illness with the implication that they would be helpful for his two sons who are ill with “the same thing” (as he mentioned earlier in the encounter). In response, the doctor first explains that this is a possibility and that is why he performed a throat culture to test for the strep bacteria. However, following lines 35–36 and 38, the doctor goes on to offer to give the antibiotics against his medical judgment if the parent insists. I want to note three things in this case: First, the physician overtly displays himself as oriented to the relevance and the importance of parent acceptance of a nonantibiotic recommendation and thus to the father’s participation in the decision more generally. Second, the physician treats the parent’s narrative about his own experience with antibiotics as pressure for antibiotics. In fact, he treats it as just one step short of “insistence.” That is, in saying “if you (.) absolutely insist” (line 35), the physician treats absolute insistence as having not yet occurred. However, as a condition that is being discussed, the physician further conveys his understanding that this is the behavioral trajectory the father has been on. Thus, even when parents may not be “intending” to insist or demand, they may be heard that way by physicians. Third, 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.

More typically, that the parent and physician are in a negotiation of the treatment decision is not brought to the interactional surface, but parent resistance can nonetheless be seen to initiate a negotiation if physician responses are examined. For instance, consider a case shown earlier in Extracts 5a and 5b. In the previous section, I mentioned that the father here shifts (line 27–28) from passive to active resistance. Now, I would like to focus on the way that the physician responds to this shift.

(5c)

((8 lines omitted following 5a))
 25 DOC: She: doesn't have anything right no:w,
 26 any symptoms of mucus or vomiti[ng that's contagious.
 27 DAD: => [Are you gonna give her
 28 ana- antibiotics?
 29 DOC: Yeah- uh No: I don't have anything tuh treat right now
 30 -> for antibiotics.

31 DOC: -> Her ears look really goo:d,
 32 DOC: -> .hh she has no sign of bacterial infection right no:w?,
 33 DOC: -> .tlkh and that's (what) she'd get antibiotics fo:r.
 34 DOC: .hh So uh lotta times you can start out with uh virus
 35 like uh co:ld, (.) .h an:d if you- it goes on for uh while
 36 #uh:# bacteria (should) set in you can get uh secondary
 37 -> bacteria infection? and that's when you need antibiotics.
 38 DOC: .hh #But- y-# otherwi:se: since she doesn't have any source
 39 of an antibi- of uh bacterial infection?, that=uh=we just
 40 -> watch her.
 41 (0.3)
 42 DOC: right now. <Her ears look really good, <an' her tubes are
 43 -> in too:..
 44 DOC: -> .h And they're not draining or any[thing].
 45 DAD: => [It just means that-
 46 => ya know if she gets another fever we hafta bring her ba:ck,
 47 DOC: .hh Well what I'll do is she might still get uh fever: in
 48 thuh next couple uh #da:ys.# because: .h that's th' way
 49 viruses wor:k?, you can have- you know (how have=you)
 50 if you have uh co:ld, you can get a fever for uh few da:ys?
 51 .hh And tha:t Since she's o:lder:, .h if something's
 52 #uh# she (would) com[plain () thuh symptom,=
 53 GIR: [()].
 54 DOC: =then she would need tuh come back.
 55 DOC: .hh But what you ca:n do i: [s-
 56 GIR: [Guess wat.

The father has not yet accepted the physician's proposal of no prescription treatment, and in overlap with the physician's reassertion that there is nothing really problematic wrong with his daughter, the father asks about antibiotics—an alternative treatment proposal. This question is one type of overt negotiation (other examples were shown in Extracts 4b and 7). Overt negotiation is a particularly strong form of pressure (Stivers, 2002a), especially as a resource for resisting the offered treatment. In response, the physician first answers the question (line 29). She then goes on to account for her answer, stating that there is nothing to treat at this point (lines 29–30). The father does not offer acceptance. Next, similar to how physicians responded to passive resistance, the physician restates a physical examination finding (line 31). Following no uptake again, the physician restates her diagnosis of no bacterial infection (line 32). The father still does not accept, and the physician expands her treatment recommendation further, reruling out the need for antibiotics (line 33). Again, there is no acceptance. At this point, as in other cases, the physician shifts to a scenario in which treatment would be warranted. In this way, she intimates that she may make a concession in the future. However, there is still no parent acceptance, and in lines 38–40 the physician restates her treatment recommendation.

Following 0.3 sec of silence, the physician returns to restate additional physical examination findings (lines 42–43) in the face of no parent acceptance. This is fur-

ther expanded in line 44. Here, the father again actively resists (lines 45–46). Up to this point in the encounter, the physician has been working to secure parent acceptance of the current treatment recommendation to just watch the girl for a bit longer with the intimation that if things changed, she would be willing to treat her with antibiotics. However, she has not achieved parent acceptance, and, in fact, her work has been met with still more active parent resistance. Here, the physician frames her response as a concession with “Well what I’ll do is”. This does not reach completion before the girl initiates a sequence that the physician takes up.

After the physician closes the sequence with the girl, she returns to offering a concession to the father: that he could call rather than coming back in (lines 65–70). The physician also intimates (in line 70 with “talk to us and see:_”) that the physician might be able or willing to take another course of action over the phone or as a result of the phone call, further suggesting concession to the father’s pressure. However, she also maintains her stance in favor of the current treatment recommendation to watch the girl.

(5d)

((8 lines of conversation with GIRL not shown))

- 65 DOC: .hh Uhm: mlk but usually what you can do is if over tuh
66 next few days she might still get a fever of (a hundred an’
67 -> two) you can give us a call if you’re concer:ned.
68 DOC: .h And if it goes on more than tha:t, .hh she might
69 need tuh come in #but:# .h most uh thuh time you can
70 -> just uhm call us and talk to us and see:_
71 DOC: =If she has uh new symptom, breathing difficulty:?,
72 DOC: .hh if she had ear draina:ge, if she s:- did start
73 -> tuh limp, then we would say she does need tuh come in.
74 DOC: .hh But for uh child her a:ge, you c’n get fever for uh few
75 day:s, an’: as long as she looks this goo:d, an’ no other
76 -> symptoms, .hh ya know we just- we’ll watch her.
77 DOC: So like if she got uh fever this afternoo:n that doesn’t
78 mean she needs tuh come in right away:_ What I would do
79 is like you did: this morning, .hh give ‘er some
80 Tyleno:l, If she .h looks great like thi:s then it’s-
81 -> she’s probably still just fighting off thuh virus.
82 (0.3)
83 DOC: -> Mka:y:?
84 -> (0.8)
85 DAD: °Mkay.°

In lines 71–73, the physician suggests that only certain circumstances would require the parent to return to the office. The parent still does not accept the treatment proposal. In lines 74–76, the physician restates her treatment recommendation that “we just- we’ll watch her.”. However, this restatement still does not engender acceptance. Following this, she also redoes her treatment proposal to include a rec-

ommendation of something the parent can do to be more proactive in line 79–80,¹¹ and once again restates her diagnosis. This action is met with 0.3 sec of silence. At this point, the physician overtly pursues acceptance with a heavily question-intoned “Mka:y:?”, and after a substantial delay, receives a quiet and minimal acceptance from the father (line 85).

This case provides evidence that, when physicians face treatment resistance from parents, they orient to this as initiating a negotiation of the treatment recommendation and work to secure parent acceptance. Although this physician did not ultimately modify her treatment recommendation from no antibiotics to antibiotics, she could nonetheless be seen to be making concessions to the parent, including suggesting the parent could call if the child got worse and suggesting that Tylenol would work to bring down the fever. Therefore, he would not need to return to the office.

A similar case is shown in Extract 8. Here, as part of her diagnosis, the doctor denies sinusitis¹² (lines 1–2) and then moves into her treatment recommendation beginning in line 4. The mother aligns with the doctor’s recommendations first by inquiring about a decongestant that is in the general category of Sudafed, which was recommended by the doctor (line 8).

(8a) 2016 (Dr. 9)

- 1 DOC: ^Ya know, I probably_ (0.5) wouldn’t call it sinusitis
 2 right now.
 3 (0.5)
 4 DOC: Uhm- h- What I would do: is keep up with thee uhm
 5 h over thuh counter- you know maybe like children’s
 6 Sudafe:d or something like that to help with thuh:
 7 thuh congestion in her nose.
 8 MOM: -> [Now shu- we should (be giving) her uh deconges[tant].
 9 DOC: [.hhh [h h h

¹¹A similar instance of this shift from a recommendation to do nothing to a recommendation to do something was seen in Extract 4a, in which the physician first suggested waiting and then suggested lots of fluids. Although only an incremental shift in position, this change may nonetheless be responsive to parent resistance of a “do nothing” approach to managing their child’s illness.

¹²This was a concern implied early in the visit. The mother offered only the symptom of a runny nose as her problem presentation. However, apparently drawing on the patient’s chart, the doctor offered for confirmation a description of the color of the discharge. Built into this turn is the doctor’s understanding that the discharge is currently “greenish,” thus conveying the understanding that the parent is worried about sinusitis.

- 1 MOM: She’s [had uh r- runny nose off an’ on for about two weeks.
 2 DOC: [Uh huh ()
 3 DOC: Okay:_
 4 (0.8) ((DOC hearably erasing something))
 5 DOC: -> An:d initially: was it kinda clea:r? an’ then it
 6 -> started [g e t t i n g t h i s: greenish color,
 7 MOM: -> [Initially clear but it got (.)green. [Right.

- 10 DOC: Yiea:h, I think that would probably help.
- ((35 lines of talk about different types of decongestant not shown))
- 46 DOC: .hh Uh- but certainly if thuh fever goes up higher than
47 just this low grade ninety nine or uh hundred.
- 48 MOM: [Okay,
- 49 DOC: [. h h Uh:m tlk <Or if: uhm> (.) this doesn't seem
50 to be going away.<but let's see=today's Thursday.
- 51 DOC: .hh If she definitely has any more green stuff coming out.
52 cuz I could just be hitting 'er at a good day
53 where it's drained down [thuh back [of her throat=
54 MOM: [Right. [I was gonna say=
55 DOC: =[an' I'M NOT SEEING ANYTHING.
- 56 MOM: -> =[YOU'RE NOT SEEING it on her
57 throat or anything.
58 (.) ((Possible head shake by DOC))
- 59 MOM: Oka[y.
- 60 DOC: [Uh uh.
- 61 MOM: [Okay.
- 62 DOC: [.hh Uhm .h but: if ^it's persisting: into next week.
- 63 MOM: Ok[ay.
- 64 DOC: [I mean_ Then I think we should see her ba:ck.
- 65 MOM: [Okay.
- 66 DOC: [I mean- and think about °sinusitis.°

Following the parents' alignment to the proposed treatment, the physician had appeared to complete the treatment recommendation and to have moved into plans for future action—a move into closings.¹³ This can be seen here in lines 46–47 and 49–53. However, in line 54, the mother offers a slightly premature “Right.” that may be working toward speaker transition (similar to “Yeah”, as discussed by Jefferson, 1983), and then immediately on possible grammatical completion, the mother initiates a turn of active resistance (line 54). Here, she requests confirmation of the physician's previous diagnostic findings, thus asking the physician to retreat into an earlier activity (something shown in previous cases).

In overlap, the physician shifts from her previous straightforward plan for future action to competitively addressing the mother as resistant. The competitiveness of the physician's talk is shown in that it is substantially louder than her other talk. In addition, her second TCU “an' I'M NOT SEEING ANYTHING.” restates her examination findings.

¹³Here the physician offers a straightforward plan for what should be done in the future. In previous cases in which doctors introduced plans similar to this, it was offered by way of suggesting when they would reconsider treatment or by way of addressing when the parent would need to return to the office. In Extract 8a, by contrast, the plan is a move toward closing the encounter by providing a straightforward future action plan.

Although I cannot confirm whether or not the parent further responds visibly, after a micropause, the parent accepts this with “Okay.” The physician returns to a future plan of when to see the girl back and, here, offers further addressing of the parent’s resistant action—that she might consider “sinusitis” at that time (line 66). Following this, the doctor offers another type of concession to the parent—that they could consider doing an X-ray of the sinuses. However, rather than resulting in full acceptance, the mother’s resistance to the current line of diagnosis and treatment is increased. Although she accepts the physician’s position of not liking to X-ray children (line 71), she then goes on to offer a brief narrative about her older daughter who was also without the classic sinusitis symptom of heavy nasal drainage but who apparently had a severe infection.

- (8b)
- 67 DOC: .hh We can always get- just uh plain X ray: of
 68 thuh sinuses. An’ sometimes that’s helpful when-
 69 on these equivocal things.
 70 DOC: <I don’t like to X ray kids uh lo:t but- [.hh
 71 MOM: [Right.
 72 DOC: If we’re not su:re uhm if it doesn’t sound really
 73 clear cu:t, .h we can- (.) >get an X ray.<
 74 DOC: She’s not really tender,
 75 DOC: .hh [over her sinuses either.
 76 MOM: [Yeah.
 77 MOM: -> My older daughter- I brought her in: This was two
 78 -> years ago an’ they s[aid “well we don’t think it-”
 79 DOC: [Uh huh,
 80 MOM: -> We- she had no:ne uh thuh symptoms of sinusitis.
 81 DOC: [Uh huh:,
 82 MOM: -> [(ever.) An’ she had headaches for uh yea:r?
 83 DOC: Yeah.
 84 MOM: -> An’ when they finally X rayed her she was [totally blocked.
 85 DOC: [just socked in,

The mother’s narrative is, like the previous examples of treatment resistance, positioned late in the counseling phase of the encounter and further is positioned after several recommendations with which the mother has aligned. The mother’s narrative conveys her position that she would like an X-ray of her daughter’s sinuses because in the past the X-ray revealed sinusitis with her older daughter. Like the situation the mother is in at this point in the encounter, in her narrative she relates doctors telling her “we don’t think it-” (line 78), which appears on its way to denying sinusitis (precisely what this physician has done earlier in the encounter). Although this position is embedded in her narrative, it is nonetheless conveyed. This type of resistance is primarily focused on the diagnosis and ways to detect sinusitis. Thus, unlike some of the other types of active resistance shown, here a symp-

tomatic treatment recommendation is being resisted through a challenge to the underlying diagnosis.

The doctor responds by dealing with both the mother's position in favor of an X-ray and her use of this as a vehicle to resist a lack of prescription treatment. First, the doctor agrees with the mother's narrative as plausible (line 86). She then provides an account for a lack of drainage and having a sinus infection with "it's so blocked" (line 90). However, she also asserts that the decongestants may allow drainage to begin. The doctor's turn effectively disagrees with the mother's position in favor of an X-ray. However, the doctor's opposition is embedded. She provides a condition under which she does recommend X-rays, and the contrast is built through the use of "will", along with its contrastive stress (line 88). In addition, the doctor focuses her turn on how the treatment she has recommended may help: it may help allow the drainage to begin, if in fact the mother is right about her daughter's condition. This is another way that the physician displays her understanding that she and the parent are still in negotiation of the final treatment decision.

(8c)

86 DOC: => Yeah:.

87 DOC: => .h That's why especially in kids (>who're<) complaining
88 => of headaches an' things like that I will get an X ray.

89 MOM: Right.

90 DOC: => ^Because uh lotta times it's so blocked 'at n(h)othing's
91 => dr(h)aining [ou(h)t.

92 MOM: [Ri:ght. [Right.

93 DOC: => [. h h And what you may find (.)
94 => Her nose doesn't look particularly swollen er anything
95 => inside but you may find if you- consistently give 'er
96 => thuh decongestants for uh couple days, .hh that it opens
97 => up: thuh passages t' thuh sinuses.

98 DOC: => .hh An:' [an' you'll start seeing thuh stuff coming ou:t.
99 MOM: [() [seeing it.

100 MOM: [Qokay.

101 DOC: => [. h h An' then- I mean I would: at this point if she
102 => comes back in on Monday h=er- or Tuesday and stuff-
103 => I would have prob'ly uh lower- since it's been: (.)
104 => continuing for all [this time_ .h]h to start her on=
105 MOM: [Right. right.]

106 DOC: => =some antibiot[ics.

107 MOM: [Right.

108 DOC: => <But I hate to- tuh put her on if she doesn't really
109 => nee:d it.

110 MOM: -> ^okay. That's fine.

The doctor also offers a possible concession in that she states that she would be willing to start the girl on antibiotics if the condition persisted into the next week

(lines 101–104/106). The doctor’s response also addresses the mother’s action as resisting her treatment recommendation. Specifically, she again denies the need for antibiotics at this time (lines 108–109). Having previously outlined her treatment recommendation and having moved from treatment recommendation into recommendations for other future action, such as when to bring the girl back to the office, this action is specifically a return to her treatment recommendation. As such, it is hearably responsive to the parent’s resistance. The mother then accepts the doctor’s decision with “^Okay. That’s fine.” (line 110). This acceptance is the most full acceptance provided throughout this phase of the encounter. Although “^Okay.” alone might have been equivocal as a move to accept and close the sequence, given a context in which “okay” has been used repeatedly at various junctures in the discussion, “That’s fine.” is much stronger as an acceptance of the doctor’s position and further as taking a position of closing the sequence. This example again shows elaborate negotiation of the treatment recommendation, including two concessions by the physician: (a) the offer to do an X-ray to confirm the mother’s concern that it is sinusitis and (b) the physician’s offer of antibiotics if the condition is not better by the following Monday or Tuesday. The latter concession especially appears to work, and the mother shifts from “Okay” and “Right”—acknowledgments that had been offered previously—to a fuller form acceptance: “^Okay. That’s fine.” (line 110).

An extreme exemplar. Of course, the most extreme concession a physician can make is to alter the treatment recommendation from no antibiotics to antibiotics. Although this is relatively rare, that it happens at all provides strong support for the power of treatment resistance and, more generally, the orientation to parent acceptance of treatment proposals as required. An instance is shown in Extracts 9a–9d. Here, in lines 1–2 of 9a, the physician recommends against antibiotics, but the parent does not accept. The physician expands her treatment recommendation against antibiotics in line 3 with an increment (Schegloff, 2000). The parent does not accept this either. The physician then affirmatively states that she would like to treat the girl’s eyes and give her “some decongestant” (lines 4–5). She provides a rationale for that recommendation in lines 6–7. The parent continues with passive resistance and then initiates active resistance during the 68 lines of talk that I have excluded from this analysis.

(9a) 2019 (Dr. 6)

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

((68 lines including passive and active resistance not shown))

76 MOM: But anyway she's had low-grade temp [(an' uhm), (1.1)
 77 DOC: [Mm hm.
 78 MOM: just really hasn't been hersel:f. It's- it's-
 79 MOM: It's:=
 80 DOC: =M[m hm.
 81 MOM: [(ya know)/(even) more than: uhm (1.5) thee eye thi:ng.
 82 DOC: Uh huh:,
 83 MOM: <I mean I usually don't- I- I usually wait to bring her in
 84 at least until [().
 85 DOC: [You wait unti- Yeah:,
 86 DOC: .hhh Uh: [m-
 87 MOM: [Cuz it's such a big deal to come here [()
 88 DOC: [Yea:h,=h

In lines 76 and 78, she asserts that her child simply is not “well”—that she is sick. The implicit claim appears to be that her daughter is “sicker” than the doctor’s treatment recommendation would suggest. This is pursued further and more explicitly in line 81, where she says “it’s more than thee eye thi:ng.” Finally, in lines 83–84/87, the mother suggests that normally she is very “troubles resistant” (i.e., not a mother who rushes her child to the doctor). Again, the implication is that this is more serious than the doctor’s treatment recommendation would suggest.

The next component of the interaction is shown in Extract 9b. Here, the physician begins a turn that appears more concessionary. She first agrees with the parent with “Yeah” (line 88) and then with “I mean: if you wa:nt ya know-”, which begins to frame her forthcoming response as a concession to what the parent wants. Note that the parent has not yet explicitly stated anything that she wants or expects, but she has (a) passively resisted the physician’s treatment recommendation by failing to accept it and (b) actively resisted the treatment recommendation by implying that her child is sicker than the doctor is prepared to recognize.

(9b)

87 MOM: [Cuz it's such a big deal to come here [()
 88 DOC: [Yea:h,=h
 89 I mean: if you wa:nt ya know- I mean she looks.=
 90 MOM: =Can I at least have thuh prescription an' I'll decide
 91 whether or not to fill it, i[n a couple day:s,
 92 DOC: [.tlk
 93 DOC: For the antibiotics[:?
 94 MOM: [Ye[ah.
 95 DOC: [Uh::m_ I really don't like to do
 96 tha:t,
 97 because: I mean .hh She doesn't look: like she has
 98 sinusitis:.

99 Ya know?,
 100 (.)
 101 DOC: Uhm, if you really wanta be su:re we can go ahead and
 102 -> take: X rays to make su:re if it's really opacify:,
 103 DOC: .hh cause unnecessary treatment for sinusitis: she can
 104 -> get resistant to uh lot of those antibiotics?,
 105 -> uh lot of those bugs. I mean.
 106 DOC: .hh An:d it's- it's not really good for her:.
 107 -> (1.0)
 108 DOC: So:: we try to minimi:ze ya know- treatment until it's
 109 -> really necessary.
 110 -> (.)

The concessionary frame is abandoned in favor of a less concessionary “I mean she looks.” that, given the no-problem physical examination that preceded this discussion, is likely to be heard as headed for another no-problem evaluation. This would be 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 90–91. The mother’s request not only calls into question the treatment recommended so far but specifically challenges the physician’s assertion earlier in Extract 9a that the she does not want to commit the girl to antibiotics at this point.

The mother’s request “Can I at least have thuh prescription” orients to the prescription as a minimal form of action and implies that it is significantly less than actually treating the child. This is accomplished largely with “at least”. The second unit of her turn “an’ I’ll decide whether or not to fill it in a couple day:s;” claims some measure of discretion (i.e., that she would not immediately fill the prescription and give her child antibiotics), as well as claiming that she would have the knowledge to determine whether and when to fill the prescription. The doctor denies her request in lines 95–98 but offers the parent a concession: They could perform an X-ray that would potentially clarify whether or not the child should *appropriately* be treated for sinusitis. 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. The mother fails to accept either the physician’s rejection of antibiotics or the concession. At each arrowed line the mother passes on an opportunity to accept the physician’s recommendation.

The mother continues to actively resist across the next stretch of interaction. 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,” the mother asserts that her daughter never looks bad (lines 113 and 115). She then claims that her daughter is not herself, thus implying, again, that her daughter is sicker than the physician is recognizing.

(9c)

108 DOC: So:: we try to minimize ya know- treatment until it's
 109 really necessary.
 110 (.)
 111 DOC: You know of course if she's s- you know looks really
 112 -ba:d, [then I'll go ahead.
 113 MOM: [(see she ne-) she never looks: ba:d. I mean [she can be
 114 DOC: [Mm hm:,
 115 MOM: really sick and she never looks-
 116 DOC: Mm hm[,:
 117 MOM: [You know: I've taken her in here with:

((20 lines not shown: examples of girl not acting sick))

138 MOM: [And plus it's her (t=her:) uhm (0.6) tlk (0.4)
 139 Uh:hm_ (0.5) °What'm I tryin' t' say:_° Emotionally.
 140 MOM: (I [mean she's been) .hh (0.8) t- you know more 'n more=
 141 DOC: [Mm hm:,
 142 MOM: =tire: [d,
 143 DOC: [Mm [hm:,
 144 MOM: [And more 'n mo:re (.) upset easily [an' stuff:
 145 DOC: [Mm hm,
 146 MOM: over thuh past couple weeks, [an' it's- it's just been building=
 147 DOC: [Mm hm:,
 148 MOM: =an' building an' bui[lding.
 149 DOC: [Mm hm.

Throughout this article, I have argued that both parents and physicians are oriented to the treatment recommendation as an activity requiring agreement between the parent and the physician. I have presented a variety of evidence for that. In this case, the physician has pursued agreement in several ways, including offering accounts for her treatment recommendations and offering an alternative course of action—the X-ray. Throughout, the parent has been unyielding in her dissent, first passively resisting and ultimately overtly requesting an alternative type of treatment.

In the final extract, the physician works to close the activity after what is now more than 150 lines of discussion of the treatment recommendation. Note that if the mother had agreed readily to the treatment following the recommendation shown in Extract 9a, this activity might have closed within just a few lines. At this point, the physician offers yet another concession—a willingness to talk to the girl's regular physician (lines 155–156; 163–164).

(9d)

148 MOM: =an' building an' bui[lding.
 149 DOC: [Mm hm.
 150 DOC: .tlkhh Who: usually sees her.

- 151 MOM: Doctor Hilton.
 152 DOC: .hh Uh:m lemme call him an' see what he uhm says.=
 153 MOM: =Oh is h[e around (today?)
 154 DOC: [Okay?
 155 I don't know if he's arou:nd but I'll=lemmme try to call
 156 him. .hh because: uh:m_
 157 MOM: He's not [().
 158 DOC: [Tlk I really don't want to treat 'er.
 159 (0.5)
 160 DOC: Uhm but then I've only seen her first time. This is my
 161 first time seeing her so I really don't know how she
 162 (.) you know i:s,
 163 DOC: .hh So let me call 'im an' see: what he sugge:st, .h An'
 164 the:n we'll go from there.
 165 (.)
 166 DOC: [Does that sound okay?
 167 MOM: [°Okay.°
 168 MOM: Sure, if you can (reach) him fit sounds great.f

Even here, after proposing to call the child's regular doctor, the mother resists when the physician reraises her treatment recommendation in line 158. The mother still does not accept this (line 159). However, when she proposes, as an alternative, that she will "see what he sugge:st," in line 163) and make a decision at that point (line 164), although the mother does not accept this immediately, she does offer acceptance in line 167. The doctor pursues more explicit acceptance in line 166 with "Does that sound okay?" and the mother more fully accepts (albeit provisionally) in line 168 with "Sure, if you can (reach) him fit sounds great.f".

Ultimately, the physician cannot reach the girl's regular doctor, and she ends up prescribing 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 (mentioned again in line 158 here). Similar to other concessions that physicians offer, this one is offered at a point when the parent has both passively and actively resisted the proposed treatment. In this case, the physician worked to convince the parent of a nonantibiotic treatment recommendation but was entirely unsuccessful. Despite the physician's strong position against prescribing, she is pressured through the normative constraint on securing parent acceptance of the treatment recommendation to close this activity. When that is not forthcoming, the physician alters her recommendation to obtain the required acceptance. Although this case offers a rather extreme and overt example of the negotiation process and the possible outcome such a process can yield, that the outcome is negotiated is, as the data have shown, not unusual. In fact, there is no case in these data when a parent fails to accept the treatment and a physician nonetheless proceeds to activity and visit closure.

This section showed that treatment resistance is a practice through which parents initiate a negotiation of the physician's treatment recommendation. I have of-

ferred evidence in support of this argument in the form of an explicit orientation to this as a negotiation (Extract 7) and in the form of proposed concessions to the parent (either possible or actual) in Extracts 8 and 9. That physicians will shift so completely in their treatment proposals (as was shown in Extract 9a–9d) provides perhaps the strongest 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 social interaction norms.

DISCUSSION

This article shows that parents participate in the treatment decisions for their children—even if at times covertly—through their acceptance of or resistance to physicians' treatment recommendations. Parent and patient participation is currently an important source of discussion in the areas of health services research and health policy. There has been an emphasis on encouraging physicians to involve patients and parents in treatment decisions. According to the goals of Healthy People 2010, patients who actively participate in decisions about their health care can positively impact national health (U.S. Department of Health and Human Services, 2000). Researchers assert that patients should, whenever possible, be offered choices in their treatment decisions (Brody, 1980; Butler, Rollnick, Pill, Maggs-Rapport, & Stott, 1998; Deber, 1994; Emanuel & Emanuel, 1992; Evans, Kiellerup, Stanley, Burrows, & Sweet, 1987; Fallowfield, Hall, Maguire, & Baum, 1990; Kassirer, 1994; Levine, Gafni, Markham, & MacFarlane, 1992). Several medical associations now recommend that physicians overtly 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 all recommend shared decision making for decisions surrounding cancer screening (Frosch & Kaplan, 1999).

The primary rationale for these recommendations is two part: (a) patients have a right to and want to participate in the decision (Blanchard, Labrecque, Ruckdeschel, & Blanchard, 1988; Cassileth, Zupkis, Sutton-Smith, & March, 1980; Ende, Kazis, Ash, & Moskowitz, 1989; Faden, Becker, Lewis, Freeman, & Faden, 1981; Thompson, Pitts, & Schwankovsky, 1993) and (b) patients have improved outcomes when they participate in medical decision making, including satisfaction (Brody, Miller, Lerman, Smith, & Caputo, 1989; Brody, Miller, Lerman, Smith, Lazaro et al., 1989; Evans et al., 1987), patient health (Brody, 1980; Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Kaplan, Greenfield, & Ware, 1989; Mendonca & Brehm, 1983; Schulman, 1979), and patient mental well-being (Brody, Miller, Lerman, Smith, & Caputo, 1989; Evans et al., 1987; Fallowfield et al., 1990; Greenfield et al., 1988). Although researchers suggest that in the primary

care context, doctors are much less likely to involve patients and parents in treatment decision making (Braddock, Edwards, Hasenberg, Laidley, & Levinson, 1999; Elwyn, Edwards, & Kinnersley, 1999; Tuckett, Boulton, Olson, & Williams, 1985), this appears to be based on the assumption that a patient or parent must be invited to participate by a physician to be involved in the decision process. This article shows that this is not the case.

This article contributes to a line of research that shows that, whether intentionally or not, parents do impact treatment decisions, even when they are not overtly invited by physicians to participate in those decisions. Although parent participation may occasionally take the form of overt pressure for a particular medication or procedure (e.g., Palmer & Bauchner, 1997; Stivers, 2002a; Weijer, Singer, Dickens, & Workman, 1998), it more typically involves communication behaviors that, although indirect, communicate a general desire for, or expectation of, a particular treatment outcome (e.g., Stivers, 2002b). The behavior shown in this article suggests that it may not be purely the behavior but also existing normative constraints that lead physicians to perceive pressure and to acquiesce to, at times, inappropriate treatment.

Although parent and patient participation in health care is widely supported, in contexts in which parent and patient participation takes the form of advocating for an inappropriate treatment such as antibiotics to treat a viral illness, their participation in health care decisions can create difficulties that physicians must manage from both a communication and a medical perspective (Barden et al., 1998; Butler et al., 1998; Sleath, Svarstad, & Roter, 1997). These findings suggest that future interventions aimed at increasing parent and patient participation need to take into account existing social norms that may already include patient and parent participation to teach physicians how to best work inside these normative constraints to secure parent and patient acceptance while supporting their participation and maintaining their satisfaction.

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APPENDIX

Transcript Symbols

Temporal and sequential relations

- [A. Overlapping or simultaneous talk is indicated in a variety of ways.
- [Separate left square brackets, one above the other on two successive lines with utterances by different speakers, indicates a point of overlap onset, whether at the start of an utterance or later.
-] Separate right square brackets, one above the other on two successive lines with utterances by different speakers indicates a point at which two overlapping utterances both end, where one ends while the other continues, or simultaneous moments in overlaps which continue.
- = Equal signs ordinarily come in pairs—one at the end of a line and another at the start of the next line or one shortly thereafter. They are used to indicate two things:
1. If the two lines connected by the equal signs are by the same speaker, then there was a single, continuous utterance with no break or pause, which was broken up to accommodate the placement of overlapping talk.
 2. If the lines connected by two equal signs are by different speakers, then the second followed the first with no discernible silence between them, or was “latched” to it.
- (0.5) B. Numbers in parentheses indicate silence, represented in tenths of a second; what is given here in the left margin indicates 5/10 sec of silence. Silences may be marked either within an utterance or between utterances.
- (.) C. A dot in parentheses indicates a “micropause,” hearable but not readily measurable; ordinarily less than 2/10 sec.

Aspects of Speech Delivery, Including Aspects of Intonation

- . A. The punctuation marks are not used grammatically but to indicate intonation. The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence. Similarly, a
- ? question mark indicates rising intonation, not necessarily a
- , question, and a comma indicates “continuing” intonation, not
- ?, necessarily a clause boundary. A combined question mark and
- comma indicates a rise stronger than a comma but weaker than a
- question mark. An underscore following a unit of talk indicates
- level intonation.
- ;
- The semicolon indicates that the intonation is equivocal between final and “continuing.”

- : : B. Colons are used to indicate the prolongation or stretching of the sound just preceding them. The more colons, the longer the stretching.
- C. A hyphen after a word or part of a word indicates a cutoff or self-interruption.
- word D. Underlining is used to indicate some form of stress or emphasis, either by increased loudness or higher pitch. The more underlining, the greater the emphasis.
- ° E. The degree sign indicates that the talk following it was markedly quiet or soft. When there are two degree signs, the talk between them is markedly softer than the talk around it.
- ° °
- ^ F. The caret indicates a rise in pitch.
- > < G. The combination of “more than” and “less than” symbols indicates that the talk between them is compressed or rushed.
- < > Used in the reverse order, they can indicate that a stretch of talk is markedly slowed or drawn out. The less than symbol by itself indicates that the immediately following talk is “jump-started,” that is, sounds like it starts with a rush.
- <
- hhh H. Hearable aspiration is shown where it occurs in the talk by the letter “h”—the more h’s, the more aspiration. The aspiration may represent breathing, laughter, and so forth. If it occurs inside the boundaries of a word, it may be enclosed in parentheses to set it apart from the sounds of the word. If the aspiration is an inhalation, it is shown with a dot before it.
- (hh)
- °hh
- £ I. Hearable smile inflection.

Other Markings

- (()) A. Double parentheses are used to mark transcriber’s descriptions of events, rather than representations of them. Thus ((cough)), ((sniff)), ((telephone rings)), ((footsteps)), ((whispered)), ((pause)) and the like.
- (word) B. When all or part of an utterance is in parentheses, or the speaker identification is, this indicates uncertainty on the transcriber’s part but represents a likely possibility.
- () C. Empty parentheses indicate that something is being said, but no hearing (or, in some cases, speaker identification) can be achieved.