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Communication in Medical Care – An ICCA 2014 report[1]

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1. Introduction

With a total of 98 panels and about 400 presenters, ICCA 2014 was a great opportunity to share the latest CA research on the order of social interaction in mundane and institutional contexts. A prominent and growing research field within CA research tradition also presented at ICCA 2014 is medical communication. At the latest since Gill and Roberts (2012) spoke of 'medical CA', it is clear how heavy the focus on interaction in medical settings has become. At ICCA 2014 there were 10 panels concerned with the field of medical CA, mostly dealing with doctor/patient interaction in various medical settings and focusing on actions and sequences in clinical encounters. Furthermore, the plenary talk by Douglas Maynard about "'End-of-life' conversations and the interaction order in cancer clinics" was located in the field of medical CA.

In this report I give a summary of the plenary address given by Douglas Maynard (section 2) and an overview of four panels: i) Doctors' orders (3.1), ii) Medical care: negotiations between doctors and patients (3.2), iii) Actions and sequences in the medical visit (3.3), and iv) Medical decision-making as an interactive practice (3.4). As the plenary as well as the presentations in the four panels revealed a significant research focus on diagnostic and decision-making activities – presentations in panels 3.1 and 3.2 concentrated solely on medical decision-making – this report also sets the focus on these two core components within medical encounters.

2. Douglas Maynard: 'End-of-life' conversations and the interaction order in cancer clinics

In the beginning of his plenary, *Douglas Maynard* brought up the applied question: "What should medicine do when it can't save your life?" as an *ex situ* motivation to explore interactions in cancer clinics with terminally ill patients. He cited surveys showing that patients gain a sense of completion when end-of-life care includes end-of-life topics. However, Maynard also drew on studies showing that physicians generally tend to keep a professional distance towards these concerns. Maynard accounted for this *ex situ* orientation towards analyzing those interactions and pointed out at the same time the relevance of taking a deeper look at the *in situ* order of oncology care interviews. He showed that oncology care interviews exhibit properties which at first glance seem to be far removed from patients' wishes: The interactions he analyzed include 'recent symptom history', 'delivery of CAT scan results' and 'treatment recommendations' as core activities; they thus revealed a significant absence of addressing end-of-life topics. Despite occurring in a context of death awareness and a likely progression of cancer, interactions between oncologist and patient in fact rarely address the issue of end of

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life. With the leading question "What is it that's not going on?" Maynard disclosed the sequential chronology of these consultations, devoting special attention to the delivery of CAT scan results.

Based on his findings about interactional asymmetries between delivering bad diagnostic news versus good news (Maynard 2003), with good news being delivered in an exposed manner and bad news in a shrouded way, Maynard stated that similar asymmetries are found in the delivery of 'post-diagnostic' scan results. He showed that all cancer consultations revealed an orientation towards good news, also treating 'news of stability' (tumor neither shrank nor grew) as good news; doctors' turns generally present positive assessments in a straightforward manner, and furthermore include a specific post-delivery sequence, the so-called *appreciation sequence*. This type of sequence was identified in a huge number of interactions and usually looks like the following (imaginary) sequence (line 3 to 5):

1	D: the tumor hasn't grown.	← *tacit laudable event proposal*
2	P: Okay.	
3	D: That's a beautiful thing	← *laudable event proposal*
4	So you appreciate that	← *appreciation elicitation*
5	P: Yeah that's great	← *appreciation*

Maynard showed that an informing-acknowledging sequence (lines 1-2) occurs as a pre-sequence to the appreciation sequence, the latter including overt appreciation solicitations when patients resist the subtle orientation to laudability (*tacit laudable event proposal*) of the tumor status. The appreciation sequence thus operates to put the clinical view 'stable news is good news' forward by making patients' appreciation relevant. Maynard pointed out that while the *ex situ* view on oncology care interactions leads to a general avoidance of delicate issues like 'end of life', the *in situ* analysis stresses the oncologists' turning to optimistic interpretations of tumor changes and thus maintaining the asymmetry between good and bad news.

In his conclusion Maynard highlighted the importance of finding the benign order of interaction instead of directly formulating *ex situ* suggestions for improving communication between doctor and patient. Breaking the internal order of interaction without acknowledging its inherent functions (e.g. conveying an optimistic view) could have far-reaching consequences, such as patients perceiving doctors' behavior as rude when doctors initiate a discussion about end-of-life issues.

3. Panels

3.1. Doctors' orders

In the four papers within this panel, current research questions and results of a collaborative project on treatment recommendations by UCLA (USA), the universities of Bristol (UK), Glasgow and York (UK) as well as the Barts & London School of Medicine/Psychiatry (UK) were presented and discussed. Finding out how doctors formulate treatment proposals with respect to word choice and action type as well as analyzing patients' responses were specified as general goals of the project.

For analyzing the treatment recommendation phase within medical consultations, 311 US-American and 220 British doctor/patient interactions were recorded. Merran Toerien, Laura Thompson, Rebecca Bames, and Clara Bergen identified a range of treatment recommendation actions used by both British and US-American physicians, such as pronouncements (*I'm gonna start you on X*), suggestions (*You should try X*), proposals (*How about trying X?*), assertions (*There are medications for that*), and offers (*Do you want me to give you X?*). The patients' responses also turned out to be wide-ranged: The widespread acceptance of treatment recommendations (*That's fine*) or acknowledgements (*I see*) alternate with passive resistance (mostly a recipient token followed by silence) or active resistance against the treatment proposal (*I don't like taking drugs like this*).

Merran Toerien presented the interactional work done by assertions in physician-initiated treatment recommendations. She raised the issue: What counts as a recommendation? Can an assertion be assumed to be a recommendation? Toerien stated that assertions have a prominent status in her corpus of interactions in neurology clinics (over 50 percent); her initial hypothesis was that assertions may have a delicacy-avoiding function in recommendations of psychological treatment to patients claiming to have neurological problems. She discovered, however, that assertions were frequently used for biomedical treatments (e.g. for anti-epileptic medications). This unexpected finding led Toerien to raise the question of whether these assertions operate sequentially as recommendations at all. Patient responses (nodding, acknowledging, silence) give us reason to assume that assertions do not have a recommending function since patients do not treat them as requiring acceptance or rejection. Toerien showed how treatment decisions in such cases are explicated: by deploying another turn in the following sequence which contains a rather clear recommendation or a "patient view elicitor". However, Toerien gave reasons why assertions should be regarded as part of the recommendation action: Patients sometimes *do* treat assertions as requiring acceptance/rejection and thus orient to the "real purpose" of the doctor's utterance. In those cases, the following recommendation sequence appeared to be blocked. It was discussed whether assertions could therefore be viewed as a pre-sequence to an explicit recommendation sequence. Toerien interpreted this practice as avoiding telling patients explicitly what they *should* do, but rather informing them what they *could* do. By using this practice doctors could further "test the water" with respect to patients' wishes and offer choices at the same time.

Laura Thompson's presentation *Decisional responsibilities and patient resistance in psychiatric treatment* focused on interactions with schizophrenia patients. The fact that the methods psychiatrists actually use for initiating treatment decisions have remained unexplored was the starting point, and contrasts with the widespread desideratum of acknowledging patients' expertise in the decision process. This led Thompson to analyze psychiatrists' methods for initiating treatment decisions, patients' responses, and the overall orientation to 'expertise' in these sequences. In 104 treatment recommendations, Thompson identified proposals and suggestions as the most frequently used action type, followed by pronouncements, offers, and assertions. Patients' responses to these initiating turns are quite heterogeneous, but show the well-documented picture of patients predominantly acknowledging treatment decisions but also resisting in 26 cases. Analyzing patients' resistance in detail, Thompson found that patients resisted in most of these cases in response to proposals or offers. Resistance further turned out to occur more frequently when a shared responsibility of doctor and patient was lexically manifest in the proposals (e.g. by using 'we'-formulations). Among the offers there was more resistance when doctors used 'you'-formulations, which Thompson interpreted as a consequence of casting patients as "agent of want". Based on these findings she focused on the means by which patients enact resistance: The most common result was patients expressing concerns about side-effects, which usually resulted in the intended medication not being prescribed. Moreover, certain aspects of turn design – hedges, 'I mean'-prefaces, and turn-initial delays – seem to be associated with psychiatrists' not prescribing medication later on. As a result of the subversion of physicians' treatment plans due to reported side-effects, patients act and are treated as co-experts within the prescription process.

Rebecca Barnes' talk An overview of physician-initiated medical treatment recommendation sequences in UK primary care started from the following explorative questions:

- What are the different ways in which doctors initiate medical treatment recommendations in UK primary care, and how do patients respond?
- How does this compare with US primary care?

Building on 434 medical recommendation sequences, Barnes presented a comparison between US and UK encounters with respect to actions used for initiating treatment recommendations. While they deploy the same set of actions (pronouncements, suggestions, proposals, offers, assertions), a different distribution was identified with significantly more pronouncements in the American data and more proposals in the British data. There were also differences regarding patients' responding actions: While British patients acknowledge and predominantly do not (verbally) take up the general practitioners' (GP) recommending turn, American patients generally accept or (at least) acknowledge the GP's recommendation. Resisting responses turned out to be the least frequent response type in both datasets. Barnes showed that in many cases, more than one sequence was deployed for making the recommendation complete, i.e. a pre-sequence initiated by an information-seeking question such as *Have you ever taken X?* These questions serve, like Toerien documented for assertions in the first presentation, as subtle perspective-elicitors: "What does the patient think about this medication?" Barnes stated that doctors' questions in these pre-recommending sequences allow a space for active patient participation. While patients' responses do not directly orient toward a recommendation necessarily being the next turn, they do in fact determine whether a recommendation is warranted. In addition, doctors mark the relation between patients' responses and their following recommendation, therefore retroactively treating it as preliminary to the recommendation. Barnes concluded that 'doing prescribing' should be viewed as a course of action across sequence boundaries, opening up space for further negotiation.

In her paper *Closing the deal – patient informedness and resistance in treatment negotiation*, *Clara Bergen* focused on treatment resistance in order to better understand variation in cross-cultural orientations to prescribing and to learn how prescribing patterns are established and maintained. By applying a quantitative approach, Bergen applied a logistic regression model to the data with 'immediate acceptance' versus 'resistance' as the dependent variable. The 'type of medication' (over-the-counter prescriptions vs. prescription), the 'location' (USA vs. UK), and the 'interaction term' (different contexts within the decision-making activity) were used as predicting factors. Bergen found out that there is a significantly higher probability of resistance for over-the-counter prescriptions in the US compared to the UK when controlled for interaction term. Thus, patients in the US and the UK resist prescriptions in different contexts. Bergen raised the question whether this finding could be interpreted as preliminary evidence that patients in the US and the UK employ resistance to promote different outcomes of medical decision-making. She further stated that resistance in different contexts display different degrees of involvement with the treatment decision.

3.2. Medical care: negotiations between doctors and patients

Virginia Teas Gill presented analyses of interactions with early-stage breast cancer patients. In her paper *I absolutely positively want both of them off* she focused on conflicts regarding treatment in surgical consultation for breast cancer. In the case of breast cancer in the US, mastectomy was replaced by the combination of lumpectomy and radiation as the most frequently applied treatment in the 1990s. Still, there has been a recent surge of interest in mastectomy among patients. Gill referred to survey literature which gives evidence for an increase of conflicts between breast cancer patients and surgeons in recent years. This led Gill to the question: How are decisions for surgical treatment of early-stage breast cancer brought forward in the clinic? Gill pointed out that talking about treatment in breast cancer clinics includes multi-unit turns in which surgeons handle several obligatory subtopics such as talking about the order of treatment (surgery first or medication first), the scope of surgery (breast or also lymph nodes), and surgical options (lumpectomy or mastectomy). Gill showed that surgeons usually display an orientation to optimally inform patients in their explanations. Moreover, they address the possibility that patients may consider mastectomy to be the optimal surgical treatment for breast cancer and thereby anticipate resistance against their treatment recommendations.

Analyzing pediatrician/parent interactions, *Nan Wang's* presentation *Obtaining services in doctors' office* focused on parent request practices in Chinese encounters. Wan first referred to Levinson (1983), who wrote about requests as sensitive matters. Thus, formulating requests is usually done through subtle practices such as reporting a problem instead of making the request directly. In mundane conversation as much as in institutional talk, requests establish the relevance of an offer to help (Curl 2006). Wang described pediatric practice in China as "busy, busy, busy", with doctors handling many patients in short time spans and examining several patients in the same room. Wang discovered that parents actively engage in requesting treatment and are influential on decision outcomes. She identified three request practices: The "canonical request", the most common form, occurs in FPP-position and takes a canonical request format. Wang showed that its straightforwardness can be mostly explained through doctors' preceding turns projecting the requested treatment. The second is the "inquiry request format", which is usually deployed in case of parent resistance to a proposed treatment in SPP-position, inquiring about the possibility of an alternative treatment with the intention of requesting something different. The "report of problem" request ties in with Drew's

(1984) findings; it takes a statement format and operates differently depending on turn position: As an FPP it is used to request something that has not been proposed by the doctor. As an SPP after a doctor's proposal, it indicates parent resistance referring back to the problem. Wang interpreted her results as in line with earlier findings about requests: While overt requests of service rarely happen in Chinese pediatric contexts, requests take more subtle forms.

In her paper *Referral suggestions and their negotiation in general practice, Christel Tarber* presented findings about referrals as a frequent interactional task in the general practice. She analyzed 197 Danish doctor/patient encounters in the general practice and found 40 instances of a referral being proposed, either by doctor or by patient. Referral actions are occasioned by diagnostic uncertainty and can thus be considered a step towards diagnosis. Tarber identified referrals as a locus for deontic authority since doctors claim "the right to determine others' future actions" (Stevanovic/Peräkylä 2012:297). With respect to this, Tarber emphasized the importance of finding out what kind of force a referral turn exerts on patients' actions. In the Danish corpus, she identified three different types of referrals which she classified as being on a continuum of deontic authority. The *no-negotiation referral*, which exerts strong deontic authority, is formatted as an announcement while giving only a minimal or no account for the referral. By directly moving on to practicalities, there is usually no slot for the patient to react to this type of referral. The second type of referrals – *hedged proposals* – orients to the relevance of patients' acceptance (and possible resistance as well) by using a tentative format with epistemic downgraders, indirect formulations, and delicate word choice. Tarber found that the no negotiation-type was used with frequently occurring medical problems with high medical legitimacy. The hedged proposals, in contrast, typically occur in contexts where general practitioners expect patients to be anxious or concerned about their illness. As a third type of referral, Tarber found *offers* which empower patients to decide whether or not to follow the referral. While this referral type does not overtly assume deontic authority, Tarber pointed out that offers usually occur as a response to patients' indirect requests. Furthermore, they are used in cases of problems with either low medical legitimacy or where a referral would not make a difference for the recommended treatment. It was concluded that the design of referrals not only reflects doctors' authority but also displays orientations to the medical urgency of the problem and its recurrence. Referrals with a seemingly high authoritative attitude thus might in some cases only display an orientation towards patients' anxiety.

Anne Marie Landmark Dalby and *Jan Svennevig* dealt with interactional patterns of treatment negotiation. They focused on *Physicians' formulations of patients' stance* as a means of negotiating treatment preferences in secondary care. They grounded their research in the desideratum of patient-centered care and presented essential elements in shared decision-making as formulated by Makoul and Clayman (2006): checking and clarifying mutual understanding and bringing up patients' values and preferences. Since doctors' behavior has so far been analyzed by standardized measurement tools (Clayman/Makoul/Harper/Koby/ Williams 2012), Dalby and Svennevig formulated their research question as follows: Which conversational practice do physicians use for bringing up and checking patients' views and preferences? Which kinds of formulations, e.g. "summarizing, glossing or developing the gist of an informant's earlier statements" (Heritage 1985:100), can be identified? Since the authors also emphasized the relevance of discussing interactional characteristics of doctor/patient talk in relation to core concepts of shared decision models, the study also aimed at exploring which interactional objectives formulations of patients' stance point to in the phase of negotiating treatment. In 140 videotaped Norwegian consultations in university hospitals, the authors found 17 cases in which physicians explicitly oriented to patients' preferences and views. The examples Dalby and Svennevig presented consistently contained assertive, 'you'-formatted formulations like "you don't want to X" or "You would like to X". These formulations not only establish common ground but also treat the patient as a responsible agent, while sometimes also conveying the physicians' (opposite) stance towards patients' preferences. Results were discussed in terms of a potential expansion of core concepts of shared decision-making: Doctors not only take up patients' views but also get the patients' wishes "on the record" in order to (re)negotiate and/or challenge the patients' stance and convey the physicians' opposite stance. For future research, the authors raised the question of whether shared decision-making based on a partnership model of the doctor/patient relationship involves the dimensions of increased accountability and challengeability of patients' stance.

3.3. Actions and sequences in the medical visit

Timothy Halkowski talked about *Responding at a 'higher level' to advance (and/or contest) the activity in discussions of tobacco use*. He started with the observation that patients often provide unrequested information in response to questions like *Do you smoke?* by not only responding *yes* or *no* but for example: *I'm a trying-to-quit smoker*. Considering previous findings (Lee 2011), Halkowski pointed out that these non-type-conforming responses are ways to anticipate and orient to 'higher level' institutional activities. Halkowski related his observations to the concepts 'cooperation' and 'progressivity' which can be enhanced or undermined by a 'higher-level' response, depending on the context in which the sequence implements a particular task. In case of problematizing the higher activity, Halkowski stated that this might be a way to resist against the physician's epistemic authority as well. Accordingly, he concluded that a key feature of patients' responses is to show themselves to be proper, knowledgeable patients. This work can be treated by the doctor as sufficient or insufficient and being either facilitative of or counter to the current project.

Also taking into account physicians' epistemic authority, *Alexandra Gross* focused in her presentation on *HIV and medical expertise – The example of decision-making in the HIV-encounter*. She analyzed routine doctor/patient encounters in a German outpatient clinic for HIV-positive patients in which the effectiveness of HIV medication and patients' physical well-being is regularly checked. Treatment negotiations are not obligatory parts of these talks, but occur in cases of HIV-therapy side-effects and if patients mention HIV-unspecific concerns during the encounter. Gross introduced the concept of (physicians') 'expertise-in-interaction', concerning doctors' and patients' orientation to (their own and/or the doctor's) medical authority and the performance of a specific expert role with associated interactional rights and responsibilities. She applied the concept to the analyses of how treatment decisions are accomplished. Gross identified different actions depending on the HIV-specificity of the reported concern. For HIV-related treatment decisions she found recommendations (mostly "I would recommend X" format) as the dominant action type. These are frequently embedded in lengthy multi-unit turns giving an account in favor of the preferred treatment. In contrast, offers and 'perspective-taking recommendations' ("(If I were you) I would do X") were the most common actions dealing with HIV-unrelated concerns, with offers mostly formatted as "You can do X". Gross interpreted her results in terms of physicians' accountability (Peräkylä 1998) and patients' expertise and personal responsibility, especially with respect to HIV-unrelated concerns. She concluded that 'you'-oriented offers as well as perspective-taking recommendations can be viewed as means for constituting a partnership model between highly knowledgeable patients and highly specialized HIV doctors, thereby being interactive practices of shared decision-making.

Sanni Tiitinen and *Johanna Ruusuvuori* talked about *Applying CA to studying gendered parenthood in preventive maternity and child health care*. They focused on parent/nurse interactions in maternity and child health clinics (MHC) in Finland which are attended by parents for preventive, voluntary, and free check-ups both during pregnancy and after the birth of the child. The authors embedded their research in sociological concerns of family policy striving for equality and shared parenthood as desiderata in contrast to still-prevalent "gendered" parenthood (Haataja 2009). Aiming at an analysis of the interactional production of gendered parenthood based on ideas of feminist CA (Kitzinger 2008), Tiininen & Ruusuvouri first focused on gaze as a turn-allocation device in a three-party talk between a nurse and both parents. They showed that nurses predominantly gaze at mothers after posing a question that is verbally directed at both parents, with the consequence that it is the mother who responds first (Tiitinen/Ruusuvuori 2012). Fathers were seldom treated as the principal respondent by gaze contact and thus only rarely responded first. Their current research (Tiitinen/Ruusuvuori in press) deals with question design in talk about topics related to shared parenthood, analyzing how questions implement "secondary parent roles".

In their paper *I understand what it is but I didn't expect to get it*, *Maria Stubbe* and *Kevin Dew* dealt with justifications for delayed presentation in accounts of newly diagnosed diabetes patients. 32 newly diagnosed patients were audio-/video-recorded for several months in primary care encounters. Stubbe and Dew aimed at identifying practices of self-presentation and justification in the patients' accounts. The authors found that patients express surprise towards the diagnosis but at the same time display knowledge about diabetes and diabetes risk. Stubbe and Dew explored the heterogeneity – in form and content – of patients' accounts for not having prevented diabetes or not having anticipated its risk. Accounts ranged from trivialization of symptoms to insistence on correct health behavior to admitting awareness of being at risk. Justifications were shown to be interwoven in narratives of symptom discovery, as was previously documented by Halkowski (2006) as well. Stubbe and Dew pointed out that patients' responses were designed to position themselves as credible and reasonable patients. They concluded that this is enacted through displays of knowledge and an orientation to being accountable for past actions.

3.4. Medical decision-making as an interactive practice

Christopher Koenig's presentation dealt with *(Re)formulating treatment – Enabling and constraining patient treatment decision-making in primary care visits*. Based on analyses of 100 video-recorded interactions, Koenig identified '(re)formulations' as being relevant for a better understanding of how physicians deal with new, previously unmentioned medical problems in the treatment decision phase. Formulations are defined as practice in which a lexical item is meaningfully selected to relate to the gist of ongoing talk; they have repeatedly been documented in ordinary conversations (Enfield 2012), e.g. to refer to persons, places, or times (e.g. Schegloff 1972). A 'reformulation' is thus a second reference in which – according to Koenig's working definition – a speaker employs two or more alternative lexical items for the same referent. Koenig showed how reformulations are used by physicians to re-refer to the proposed treatment within the same or in the next turn. Physicians tend to start with general formulations and turn to more specific expressions for medical treatments, e.g. from the general class of medication to its precise name. By soliciting recognition and explaining the purpose of the recommended treatment, physicians try to obtain patients' agreement and avoid their resistance.

The paper *Patients' requests and psychiatrists' responses in decision-making over treatment* by *Shuya Kushida*, *Takeshi Hiramoto,* and *Yuriko Yamakawa* focused on the way in which patients make requests in psychiatric treatment negotiations. Requests in clinical contexts – especially overt requests – have been described as rare and thus atypical actions. Requests in medical consultations are regarded as a delicate matter, since they might constrain doctors' following action and call their medical authority into question. Two main research questions were raised:

- How do patients use explicit forms and less explicit forms to make requests?
- How do the two formats shape the trajectories of decision-making?

Kushida et al. stated that requests do occur in psychiatric interactions, but not in every encounter: In a total of 82 consultations, they found 30 instances of request-making in 27 interactions, in some cases during treatment decisions about an ongoing treatment, in other cases when new treatments were requested. Kushida et al. distinguished 'explicit requests' such as imperatives and statements of desire from 'implied requests', e.g. mentions of past or possible treatments. Their quantitative results showed that explicitness of request correlates negatively with newness of treatment: Patients are more likely to request medication in an explicit form if it is already well-proved, thereby orienting to the treatment as though they were entitled to get it. Conversely, patients display less entitlement to receiving new medication by putting forward their requests implicitly. Kushida et al. found that psychiatrists granted explicit requests for already-known treatments without exception. In contrast, requests for new medication were more likely to be granted when made implicitly. Kushida et al. concluded that patients systematically choose between explicit requests vs. implicit requests so as to maximize the possibility of getting the treatment they want and, at the same time, to avoid appearing to be "unreasonable" patients. In the face of patients' requests, psychiatrists also face two different (sometimes contradictory) requirements: to control patients' treatment sufficiently and to ensure patients' compliance with the treatment.

Leah Wingard reported on *The role of assessments in decisions about changing medication in type 2 diabetes visits*. The aims of the study were to find out how blood sugar assessment sequences are organized and how assessments are negotiated to reach medical decisions. Wingard pointed out that the assessments in professional contexts like diabetes visits are adjusted to the ongoing institutional task and contribute to its achievement (e.g. Lindström/Heinemann 2009). Within type 2 diabetes encounters, blood sugar values are the essential parameters for patients' state of health. Wingard showed that positive assessments of blood sugar are often produced in a straightforward way. In contrast, negative assessments were uttered in a delayed manner, with patients predominantly being first assessors. Wingard connected these findings to the *perspective display series*, as described by Maynard (1989, 2003): It is an assessment-eliciting strategy used to ensure alignment as the preferred outcome. Wingard draws parallels to the delayed assessments in cases of adverse blood values against the unmarked case of both participants producing closely matched positive assessments in straightforward ways.

Michie Kawashima dealt with *Story-telling in medical decision-making processes* in acute care visits in emergency rooms by patients who are facing a life-threatening situation. In this setting, family members represent patients as conversational partners because patients are in most cases unconscious. Kawashima emphasized that medical decision-making is difficult in this context, not only because family members have to decide for the patients in matters of life and death but also because time is pressing. She found out that one core element of the acute care visits is the doctor giving explanations about patients' status as a precursor to decision-making, alternating with perspective display eliciting inquiries (Maynard 2003). Storytelling was found to be a frequent practice of explaining. In other talks in contrast, physicians only produced online commentaries (Heritage/Stivers 1999) to expose their thoughts concerning the patient's status. Kawashima interpreted the latter practice as displaying medical authority more explicitly, while storytelling and inquiries of families' perspective displays doctor's accountability and constitutes a way to help families to co-decide and accept the situation.

4. Concluding remarks

The numerous panels exploring communication in diverse medical settings revealed a growing interest in the social order of medical institutions. Strikingly, there was a focus on decision-making and treatment negotiations, often related to concepts such as 'authority', 'expertise', 'accountability', and 'resistance'. Actions and (series of) sequences in which therapies and medications are negotiated have an impact beyond the encounter; they affect patients' actions in their everyday lives. Hence, medical decision-making seems to be a converging point for specific power relations – constituted, negotiated, and modified step by step within the sequential course of the activity.

Most of the presentations of medical CA focused on verbal aspects of interaction, partly because of ethical reasons and constraints on collecting video-recordings in medical institutions. Therefore, I suggest that a desideratum for future research is to take a systematic and comparative look at visual practices of medical interaction. Identifying the "medical ways" of combining and coordinating verbal and visual resources in their constitutive role for building actions in medical interactions can tap into the full potential of CA methods. In this sense I am curious about future efforts and looking forward to ICCA 2018 in Loughborough, UK.

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