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Chapter 13

# Disposal Negotiations in General Practice Consultations

Paul ten Have

## 1. Introduction

I take *negotiations* to be those interactions in which parries at the outset take a stand that differs one from the other, after which they put forward various alternatives, together with assessments of the acceptability of those alternatives, which may lead to a settlement when one aligns with the other or when they agree on a compromise. Negotiations can be explicit, as in various kinds of bargaining, or implicit, as in conversational 'negotiations' about the course of the conversation, versions of 'what happened' or implied identities.

In this chapter I explore some issues regarding negotiations in medical settings, i.e. GP (General Practitioner) consultations focused on decisions regarding case disposals.[1] The substantive 'negotiations' of doctors and patients are mostly carried on implicitly, almost furtively, while only sometimes assessment, advice and treatment is given the form of a bid in a 'negotiation'. This suggests important but difficult analytic issues of 'form' versus 'content'. For participants, the interaction in consultations is 'framed' by the fact that it occurs in that particular institutional setting. And specific interactional episodes are for them, in addition to that, situated in their common history, including specifically the course of the consultation so far.

To begin, I will use Maynard's (1984) study of plea bargaining as a primary resource. He offers a sequential model of negotiation or bargaining that could serve as



319

a baseline for any treatment of negotiation as an interactional phenomenon. Examining fifty-two cases in which the parties had to agree some disposition, he found that:

> This is not done haphazardly, but in an orderly fashion by means of bargaining sequences consisting of (1) a turn in which speaker exhibits a position, and (2) a next turn where recipient displays alignment or non alignment with the initially exhibited position (Maynard 1984:78).

Between an 'opener', which may take the form of a 'proposal' or a 'position-report', and a (final) alignment, many things can happen, including insertion sequences, third party mediations, silences or counters, with various kinds of elaborations following from that (Maynard 1984:91-100). Preceding the basic sequence, one can find introductory material, such as Solicits and Announcements followed by Go-Ahead's (Maynard 1984:85-90). One also can have recyclings of various components and sequences. In short, negotiations can get quite complicated, but they are claimed to be similar in their basic structure, which can be, and often is, elaborated in systematic ways.

As noted, my explorations of negotiations in the medical consultation focus on the 'disposal', the final decision on what should be done with the case presented. In GP consultations, this disposal is often decided 'on the spot', brought forward at a certain moment, based on what went before and proposing what shall be done next. The literature presents quite variant pictures of medical disposals as interactional events, ranging from authoritarian order to more or less egalitarian bargaining. This chapter explores some of the formats that are used in four quite ordinary 'natural' consultations.[2]

**2. Proposal/acceptance Sequences: Analysis of A Case**

My interest in the topic of disposal *negotiation* was raised by the following utterance by a GP:

> maar vind je 't een ↑goed ↑voorstel? om het ↑zo te doen?
> *but do you think it's a good proposal to do it like that*
> (case 1: line 162)

In this, the GP refers to his own previous utterance as a 'proposal' and requests his patient to give his opinion on it, whether he thinks it is a 'good proposal', The 'but' suggests that this assessment has not yet been given although it is due.

When we look at the arger episode from which this was taken, the utterance to which the GP refers as his 'proposal' seems to be the one starting in line 138 of the transcript given below:

·h en nou (z) wat ik je nou wilde ↑voorstellen is om een
↑pijnstiller te nemen? (.) tegen de pijn?
*and well what I would like to propose to you is to take a*
*sedative to counter the pain*

In this ntterance the GP explicitly formnlates his action as 'proposing', and it is this proposal that he invites the patient to assess in line 162, snggesting that this shonld already have been done bnt hasn't. Excerpt I (below) presents the episode nnder discnssion in full.

Excerpt I, disposal episode

125 (1.8)
126→ D: ik denk dat het ↑toch eh die dat 't iets ↑is met ↑spiere↓
*I do think that after all uh that that it's something in your*
127 [wat je daar ↓hebt hè? die ↓pijn ·hh dat 't een soort e::h
*muscles what you have there that pain that it's a kind of*
128 P: [(merkwaardig)
*strange*
129 D: ↑spierpijn is,
*muscular pain*
130 (.)
131 P: ['t zit echt ↑onder m'n schouder (↑hi[e-) °dus hie[r°
*it's really under my shoulder here so here*
132 D: [·hh [jaa [ja
*yes yes*
133 P: ↓en ↓hier.[(recht er voo[r.)
*and here right in front*
134 D: [aan je [in je ↓flank ja ja ·hh want 't ↑is allemaal
*in your side yes yes because it's all*
135 D: het ↑voelt allemaal en het ↑hoort allemaal normaal ↑aan, ·hh dat
*it feels all and it sounds all normal that*
136 ademen.
*breathing*
137 P: nou ben ↑blij toe.
*well I'm happy about it*
138→ D: ·h en nou (z) wat ik je nou wilde ↑voorstellen is om een ↑pijn-
*and well what I would like to propose to you is to take a*
139 stiller te nemen? (.) tegen de pijn?

*sedative to counter the pain*
P: °↓hm↑hm°
D: dat je in ↑ieder geval je (.) laten we maar zeggen alles d'r
*so you in any case you let's say can do everything*
mee kan ↑doen.
*with it*
P: (°°hmhm°°)
D: ·hh (.) en dat moet je niet langer als een week gebruiken,
*and you shouldn't take it for more than a week*
P: (°hahhm°)
D: en dan zullen we kijken hoe het in die tijd ↑gaat,
*and then we will consider how it is after that*
P: (°jha°)
D: en zodra je (.) ↑toch niet eh tevr↑eden bent, ·hh [( )
*and the moment you are still not satisfied*
P: ['t is e:h
*it is uh*
'sn↑achts is 't 't ↑ergste °hè?°
*during the night it is at its worst huh*
D: ja
P: want dan ja dan ↑wil je slapen normaal als (.) 'k in ↑bed stap,
*because then you want to sleep normally when I go to bed*
nou e:h dan ↑slaap ik al.
*well I sleep immediately*
D: ja
P: (wa-) meestal nog wel eh of moe of eh ·hh
*bec- mostly well either tired or uh*
D: jaja [·hh
*yeah yeah*
P: [(pft)
(.)
D: nou=
*well*
P: =(w) daar word je gek van.
*that makes me crazy*
(.)
→ D: maar vind je 't een ↑goed ↑voorstel? om het ↑zo te doen?
*but do you think it's a good proposal to do it like that*

163 P: ja nat↑uurlijk, [als (°'k 'r ma- van↑af ben°).
*yes of course as long as I'm rid of it*
164 D: [eh dan e:h
*uh then uh*
165 D: ·hh dan eh (.) ↑hoop ik dat het in deze week dus afzakt, als je
*then eh I hope it will come down this week when you*
166 dus minder pijn hebt hoef je ook minder tabletten te nemen,
*have less pain you can take less tablets*
167 ·hh je begint met vier (.) per dag,
*you start with four a day*
168 P: ja
*yes*
169→ D: en dan e:h zo minder, ·hh en dan zal ik je voor die ↑neus zal ik je
*and then uh less and then for that nose I will give you some*
170 nog wat ↑neusdruppels geven dan kan je tenminste [door je ↑neus weer
↑ademen.
*nosedrops so you can in any case breath through your nose again*
171 P: [ja
*yes*
172 P: enne (.) ben ik daar ↑ook gelijk vanaf.
*and will I be free from that too*
173 D: ja
*yes*
174 (.)
175 P: en ik gebruik altijd die eh die redax↑on, die die vitamines (.)
*and I always use those uh redaxon those those vitamins...*

When we look at the interactions that follow the 'proposa1' to take a sedative, we see that the patient produces some soft and unarticulated acknowledgements, like *'hmhm',* in lines 140, 143 and 145, switching to a clearer *'ja'* (yes) in 147. These acknowledgements, following the various 'components' of the proposal, do not seem to show a strong commitment to what is proposed, rather they indicate that the patient 'understands' the doctor's words. The patient seems to constitute himself as a 'passive recipient' of the doctor's 'orders', rather than as a party to a negotiation. His switch to the somewhat more active *'ja'* (yes) in 147 may be seen as a way to prepare an incipient shift to a more active participation, which indeed follows in line 149 (cf. Jefferson 1984, Mazeland 1992). This contribution, however, is not easily seen as a response to

the proposal in progress, rather it seems to be a re-affirmation of previous complaints, possibly 'triggered' by 'satisfied' in the previous utterance by the physician (Ten Have 1989:121).

In short, the GP is seen to remind his patient in line 162 that, from 138 onwards. he is expecting a clear reply to his proposal which he has not as yet received, since the patient has only acknowledged receipt of the proposal and its elaborations, shifting to reinforced complaints afterwards. This physician, then, makes it clear that the patient should assess his proposal *for* a disposal in an explicit manner. The patient, on his pan. suggests in his response that such an acceptance is to be taken *for* granted, with a relatively soft:

ja nat↑uurlijk, als (°'k 'r ma- van↑af ben°).
*yes of course as long as I'm rid of it*
(case 1: line 163)

In this consultation, then, the disposal is enacted by the physician in the format of a proposal-acceptance sequence. By pursuing an acceptance, the physician shows that he considers his proposal to be in principle negotiable, providing *for* a non-aligning response, such as a refusal, a complication, or a counter-proposal; but the patient seems to evade negotiation of any kind. By his insistence on an acceptance, the GP does 'work' to put the patient's acceptance firmly 'on record', as an interactionally-established fact. It might be part of a *more* or less deliberate strategy by the doctor to have the patient confirm his 'satisfaction' with the disposal, and with the consultation as a whole. Apart from its local benefits, it might be seen to add to the patient's motivation to comply with the prescription later on.

### 3. Disposal Formats

Let us now inspect a small number of other GP consultations to see whether proposaJ: acceptance sequences involving disposals are to be found there, or, possibly, how disposals are formatted alternatively. Here follows the disposal episode from my Case 2.

Excerpt 2 (transcribed by GaiI Jefferson)

196 D:→ ·t·hhh ( ) get your chest X-rayed at the:, just at the
197 mass X-ray unit Missiz: Murphy
198 (2.8)
199 D: ↑How old are you?

200 (0.3)
201 P: ·t·hh Twenty seven,
202 (0.3)
203 D: ((soft whisper)) ° °( )° ° ·hhh
204 (2.2)
205 D: ·t·hhhhh
206 (5.1) ((writing))
207 D: ·t·hhhhhhhh
208 (4.0) ((writing))
209 P: ekhh-heh ·hh ekhh ekhh
210 (0.5)
211 D: ·pt·hhh
212 P: ekhh
213 (2.7) ((paper being handled))
214 D: ·t·hhhhhh
215 (5.0) ((paper being handled))
216 D:→ Just a simple precaution this ·hhhh (.) uh:m,h ten til
217 twelve thirty two thirty til four thirty in the mass X-ray
218 jh (.) department at the General.
219 P: Uh-huh,
220 (0.9)
221 D: (Y'c'd) belt along now'n get it done straight away there's
222 no waiting you just (.) they just take you straight away=
223 P: =[Yeh
224 D: =[·hhhhhhh
225 P: (M[m)
226 D:→ [And (0.3) that's just a simple cough bottle.
227 (0.3)
228 P: Uh-huh,
229 D:→ Nothing very clever about it at a:ll. ·hhhh (0.2) I think
230 this'll settle down without doing anything very much it-
231 about it
232 P: [Yeah
233 D: [·hmhh If it doesn't,hh will you come back'n see me
234 P: Yes:
235 D: if you're not happy with the way it's going on.
236 P: Right.[Thank you,
237 D: [Okay?

238 D: ↓°Right.°
239 (0.6)
240 D: ↑Bye bye no[w
241 P: [Bye bye:.

In line 196-197 the doctor simply announces his disposal: further examinations by X-rays:

> .t.hhh ( ) get your chest X-rayed at the:, just at the
> mass X-ray unit Missiz: Murphy

He leaves a (2.8) pause, but there is no vocal reply from the patient. Then he engages in some administrative questioning, evidently writing the reference for the X-ray examination (lines 199-215). Having handled the referral form, he reassures the patient and instructs her on how to proceed (lines 216-225). In line 226 the physician announces another part of the disposal:

> And (0.3) that's just a simple cough bottle.

The pronoun 'that' in the announcement probably refers to a prescription being written or handed over to the patient. The medicine is described as a rather simple one: 'just a simple cough bottle.'. The announcement is acknowledged by the patient with an 'Uhhuh,' (line 228). Then a physician adds another kind of 'mitigation' of the medication:

> 'Nothing very clever about it at a:ll.' (line 229).

Added is a kind of forecast that the disorder will pass quite easily, which is, in a way, another mitigation to the medication. This is accepted with a 'Yeah' (line 232). Then the physician adds a right to return if the disorder doesn't clear up to the patient's satisfaction (lines 233-235). The patients accepts this rather strongly, confirmed by the doctor (236-238). Following that, the patient 'thanks' the GP and departs.

In this case, then, the double disposal was 'announced' rather than 'proposed'. No formal acceptance was provided or requested in the first instance, but the patient cooperated fully in the further processing of the disposal, including 'yeah'-receipts to the instruction. The second disposal was acknowledged rather than accepted as such. But the disposals as a set, and the consultation as such, seem to have been accepted through a 'spontaneous' 'Right. Thank you,', followed by an 'Okay? ↓°Right.°' from the physician.

Although the two parts of the disposal were announced rather flatly, they were, as noted, both followed by what I have called 'mitigations':

216 D: Just a simple precaution this ·hhhh (.) uh:m,
...
226 D: And (0.3) that's just a simple cough bottle.
...
229 D: Nothing very clever about it at a:ll.

So although this GP gave his disposal an 'announcement' format, he took the trouble to belittle its importance in various ways.

The next case to be considered, Case 3, is again from the Netherlands.

Excerpt 3 a, transcribed by Chris Driessen & Heidi van Mierloo)

116 kan ik die rooie lamp d'rop[-
*can I put the red lamp on it*
117 D: [ehhhn ((hoest))
*((cough))*
118 P: d'r op [doen?
*on it?*
119 D:→ [ja maar u krijgt er nog wat bij:.
*yes but you get something with it*
120 (1.1)
121 van mij.
*from me*
122 (0.7)
123 ook nog.
*also*
124 (0.4)
125 om in te nemen.
*to take*
126 (2.2)

This first fragment from the consultation starts when the patient asks whether it makes sense to continue to expose her muscles to a 'red lamp'. The physician approves that, but announces that she will get something to take with it. Then he starts to question her on her work, after which he examines her feet. There's no reaction from the patient to this, although she had a chance to do so (2.2 pause in line 126).

Excerpt 3 b (transcribed by Chris Driessen & Heidi van Mierloo)

228 D:→ja u moet toch maar=
*yes I think you should*
229 =(ik weet nie of) als u weer 's aan schoenen toe:bent,
*I don't know when you need shoes again*
230 (0.3)
231 P: ja ja dan koop ik 'n paar andere 's
*yes yes then I buy another pair*
232 om in me werk te lopen
*to walk on at work*
233 (.)
234 D:→probeer 't 's
*try it once*
235 (.)
236 D: ↓ja
*yes*
237 (.)
238 't ligt soms ↑fout aan de- aa[n het ↑voet(bed)
*sometimes it's wrong with the with the footbed*
239 P: [en ↑moet ik-
*and do I have*
240 (.)
241 dit is me ↑enige paar schoene met 'n ↓hak
*this is my only pair with a heel*
242 hoor dokter,=
*doctor*
243 =want ik heb [(altijd) schoene me 'n
*because I always wear shoes with a*
244 D: [uhuh ((hoest))
*((cough))*
245 P: platte hak.
*low heel*
246 (0.7)
247 want ik kan ↑slecht op deze schoene,-
*because it's hard on these shoes*
248 of slecht↑, maar-=
*or hard but*
249 D:→=U mag geen eh-

*you're not allowed to uh*
250 U ↑moet met hakke.
*you must wear heels*
251 (0.7)
252 P: ↑Moet met hakke?
*must wear heels?*
253 (.)
254 D: ↓ja↑:
*yes*
255 (.)
256 P: ik loop ammel op hele ↓platte schoene dokter.
*I always wear very low heels doctor*
257 (1.9)
258 is dat kwaa,-
*is that bad*
259 i-[kan dat soms ↓kwaa:d↑
*can that be be harmful*
260 D: [mwo:
261 (1.1)
262 P: ik heb [ammel van die-
*I always wear those*
263 D: [↑ja:↓a:↑
*yes*
264 (.)
265 P: platte schoene met een ↓ve:↑ter.
*low heeled shoes with laces*
266 (.)
267 D:→ n::↓ee: m'r d'r moeten hakken onder.
*no but you need heels with it*
268 (0.6)
269 [ ·hhh kijk ]
*look*
270 P: [dus ik kan dez]- deze ↑hoogte beter ↑hou↓den.=
*so I should rather keep this height*
271 D: =↑ja:↓↓ja
*yes yes*
272 (0.4)

330

273 → [ja pro↑beer 't 's]
*yes try it once*
274 P: [en ↑ik maar denken] dat 't ↑slecht is
*and I was thinking that it's bad*
275 (.)
276 D:→pro↑beer 't 's
*try it once*
277 ()
278 't is ↑net ↑net anders↓om.
*it's just the other way around*
279 (0.6)
280 P: oh (daa:'om) doe ik [↑dat!
*oh therefore I will do that*
281 D:→ [pro↑beer 't 's
*try it once*
282 (0.5)
283 ja:
*yes*
284 (0.6)
285 P: Dus ↑dit hoef'k ma ↓in te neme,=
*so this I just have to take it*
286 D:→ =Ja:: en nog 's
*yes and also*
287 en nog 'n eh-
*and also a*
288 (0.5)
289 zo'n
*such an*
290 (.)
291 sz:alf er↓bij.
*ointment with it*
292 (0.4)
293 P: ↑oké↓ ik dank u wel=
*okay thank you very much*
294 =Da::g
*bye*
295 D: Nou↓
*well*

331

296 ()
297 → pro↑beer 't 's ja.
*try it once yes*
298 Da:g
*bye*
299 ((deur))
*((door))*

We re-enter this consultation when the doctor completes the examination of the patient's feet. He suggests that, when she is going to buy another pair of shoes, she might buy shoes of a different kind (228-229). It seems that what the patient considered 'healthy' kinds of shoes, i.e. flat-heeled, are not what the doctor would suggest. The patient shows her surprise at this, but is willing to 'try' (280). She then refers to the earlier announced medication, probably referring to a prescription ('this' in 285), but the doctor announces that she will get an ointment with it (286-291). She accepts all of this with a joyful 'Okay, thank you very much' (293) and a salutation. The physician re-states his suggestion that she should 'try'.

In this case, a *triple* disposal is produced. The two medications are presented in a straightforward manner and apparently accepted in a non-vocal way. The third element, however, the suggestion that the patient should buy a different kind of shoes, is brought forward rather tentatively. It is suggested four times that she should 'try it once' (234, 273, 276, 297). But as regards the kind of shoes, he formulates his preference rather strongly, in terms of 'must' (249-250, 269). One might think that the difference in 'force' of the two medications on the one hand, and the buying of shoes on the other, as well as the fact that the buying itself is suggested as a trial, while the kind of shoes to be bought is announced strongly, might be connected to the fact that the strong formulations are related to the doctor's claimed competence, while the suggestion to buy new shoes is expressly left to the patient's discretion, i.e. her own budget considerations (cf. line 229).

In these two cases, then, both the doctors and the patients seemed to follow an announcement/acknowledgment format, rather than a proposal/acceptance one, although the acknowledgments were often 'absent' vocally and the announcements might be mitigated.

The next case to be presented, case 4, displays yet another format, let us say one of 'deliberate alternatives'.

Excerpt 4 a, (transcribed by Chris Driessen & Heidi van Mierloo)

416 D: [·hhh
417 [(0.4)
418 ehm hhh
419 (3.4)
420 → ·ik denk aan ↑twee dingen.
*I am thinking of two things*
421 (.)
422 →'t ene is
*the first is*
423 (0.8)
424 dat u 'n
*that you have*
425 (0.3)
426 'n 'n voet hebt die-
*a a foot which-*
427 (0.55)
428 normaal gesproken wordt 'n voet ↑zo afgewikkeld
*normally a foot is unrolled like this*
429 (maar bij) u
*but in your case*
430 (0.3)
431 overdreven gezegd ↑zo=
*formulated exaggeratedly like this*
432 =dat u dus as 't ware te veel op de
*that you therefore as it were too much on the*
433 (0.5)
434 onderkant van uw ↓tenen↑=
*bottomside of your toes*
435 =dus eh:[:
*so uh*
436 P: [ja=
*yes*
437 D: =aan de onderkant van de ↑voet gezien
*seen from below the foot*
438 ()
439 [·hhh
440 [(0.5)

441 en dit de tenen zijn,
*and these are the toes*
442 (.)
443 dat die hier drukt=
*that it pushes here*
444 =en dat hoort niet=
*and that's not right*
445 =want je hoort namelijk
*because you should*
446 (0.4)
447 ↑hier↓ op te lopen
*walk on this*
448 (.)
449 op de zijkant[en
*on the sides*
450 P: [↑ja↓
*yes*
451 D: [·hhh
452 [(0.4)
453 (0.3)
454 → en dat zou ↓wij↑zen op 'n beetje een ↑ingezakte
*and that could be an indication of a bit of a collapsed*
455 voorvoet.
*forefoot*
456 (1.1)
457 [·hhh
458 [(0.6)
459 → 't is ↑niet over↓tuigend.
*it is not convincing*
460 (0.5)
461 P: nee=
*no*
462 D: =as ik er zo naar kijk.
*when I look at it like this*
463 ()
464 [·hhh
465 [((0.4)
466 → 't tweede waar ik aan denk=

*the second I am thinking of*
→ =en dat is een beetje atypische ↓plaats↑,=
*and that is a bit atypical location*
=dus niet helemaal de plaats waar je 't zou ver↓wachten↑,=
*so not altogether the location where you would expect it*
→ =is aan ↓ji:cht
*is gout*
(0.6)
[·hhh
[(0.4)
→ 't enige ↑ra:re daarvan is dat u niet-
*the only strange thing is that you don't*
()
dat u dat mee-=
*that you most-*
=dat je dat meestal niet hebt
*that you mostly don't have that*
[·hhh
[(0.4)
en dat de dag daarna weer alle symptomen weg zijn=
*and that the day after all symptoms have disappeared again*
=dat is heel raa:r.=
*that is very strange*
=dat ↑klopt eigenlijk helemaal [niet
*that doesn't seem to fit really*
P: [nee
*no*
(.)
nee.
*no*
()
D: [·hhh
[(0.4)
→ dus e- en 'n derde mogelijkheid ↑zie 'k↓ gewoon niet.
*so an- and a third possibility I just don't see*
D: (0.6)
→ da ↑weet ik niet.=
*I don't know another*

491 =<laat ik 't zo maar zeggen.
*let me put it that way*
492 (.)
493 P: °ja:h.
*yes*
494 (0.7)
495 P: 'k weet ook niet
*I don't know either*
496 (0.8)
497 P: daarom kom ik bij u
*that's why I come to you*
498 (0.7)
499 P: den[k ik (dat de) dokter raad] weet
*thinking that the doctor will know*
500 D: [ja: dat is prima, dat-]
*yes that is alright that*
501 (.)
502 D: dat is uitstekend
*that is excellent*
503 (0.3)

In this case a woman patient has a complicated complaint regarding her foot, which tends to swell in a certain spot on the front part of the sole. After many descriptions and an examination, the physician states his opinion in terms of two alternative possibilities: ·hh ik denk aan ↑twee dingen. (I *am thinking of two things;* line 420). He starts by describing the first, an abnormal unrollment of the foot, which could be an indication of a bit of a collapsed forefoot (lines 422-455), but he declares that it is not a convincing possibility (line 459). The second alternative (lines 466-469) is gout, but the location is 'atypical' (467) and the timing of the symptoms does not fit this diagnosis either (473-481). The physician says he is not able to think of a third possibility (488-491). The patient reacts by saying that she doesn't know either and that she is consulting the physician in the hope that he would know (493-499).

One might speculate that the doctor, faced with a diagnostic dilemma, one in which the alternatives he considers are both not very strong, has elected to 'play' this situation out loud, so to speak. Rather than choosing one alternative and acting on it as if he were convinced himself, he shares his doubts publicly, and takes the risks that go with such an action. In this way he keeps his options open for trying either alternative and switching to the other if the first fails. The patient, however, seems to refuse to

enter the debate; if she knew the diagnosis, she wouldn't be there.

Excerpt 4 b presents a later episode:

559 [((schrijven))
*writing*
560 [(4.4)
561 D:→ ik schrijf hier 's op,
*I am writing here*
562 (.)
563 pee e(m)
*p.m.*
564 (0.7)
565 dat ik eventjes
*that I have to*
566 (0.5)
567 over nadenk,
*think about it*
568 ()
569 of althans dat we dat 's in gaten houden,
*or at least that we keep an eye on it*
570 laat 'k 't zo maar zeggen,
*let me put it that way*
571 [·hhhh
572 [(0.7)
573 → om dokter Pereboom toch 'ns te laten kijken=
*to have doctor P. take a look at it*
574 =de ortho[pedische chirurg=
*the orthopedic surgeon*
575 P: [oh
576 D: =dat ie gewoon 's kijkt van ↑hee
*that he just take a look like well*
577 (.)
578 D: i[s-
*is*
579 P: [°jah,
*yes*
580 D: is die ↑voorvoet niet te veel doorgezakt,
*is that forefoot not collapsed too much*
581 (.)

337

582 P: (°ne[e)
*no*
583 D: [ik:< >v:oel 't niet ↓maar:
*I don't feel it but*
584 D:→ >ik ben wat dat betreft 'n leek.
*I am a layman in that area*
585 (2.3)
586 P: (°n↑ou!)
*well*
587 (1.1)
588 P: (ik weet niet)
*I don't know*
589 u zegt ('t maar wat u't [beste vindt)
*you can say what you think is best*
590 D: [ja↑A:, dat lijkt me 't beste,
*yes that seems best to me*
591 [·hHh
592 [(0.5)
593 D:→ maar ik ga u wel e:hm:
*but I will give you uhm*
594 (0.4)
595 D: ik gaat:-
*I will*
596 (0.2)
597 een ding nog probere,
*try one more thing*
598 (0.6)
599 of 't dat inderdaad is,
*whether it's that really*
600 ()
601 en as dat ook niet helpt,
*and if that don't help either*
602 [hhhh
603 [(0.6)
604 dan=
*then*
605 → =<en daarom zet ik (dat) hier op de kaart<=
*and that's why I'mm putting that on this card*

606 =dan wil ik graag dat u toch 'n keer naar
*that I would like you to go one day to*
607 dokter Pereboom gaat.
*doctor P.*
608 (.)
609 P: ja
*yes*
610 ()
611 maar
*but*
612 ()
613 u wilt eerst nog wat anders [proberen?
*you want to try another thing first?*
614 D: [ja
*yes*
615 (0.4)
616 ja
*yes*
617 (.)
618 P: goed.
*alright*
619 (0.5)
620 en as dat niet helpt,
*and if that doesn't help*
621 (.)
622 D: ja
*yes*
623 (.)
624 dan dacht ik d'rover om do[kter Pere[boom te vragen
*furthermore I am considering asking doctor P. about it*
625 P: [ja [ja
*yes* *yes*
626 (3.1)
627 maar dat spreken we dan later af.=
*but in that case we will arrange that later*
628 D: =[↑ja↓:↑
*yes*

629 P: [we handelen eerst dit af [(hè)
*we will settle this first*
630 D: [↑ja precies↓
*yes exactly*
631 [(18.1)
632 [((schrijven))
*((writing))*
633 → en dat (de volgende) week of drie vier,=
*and the the next week or three four*
634 =en as u dan zegt 't helpt me eigenlijk ↑niks,
*and if you say it doesn't help me really at all*
635 (.)
636 P: ja
*yes*
637 (0.4)
638 D: dan eh:
*than uh*
639 (0.4)
640 gaan we dokter Pereboom inschakelen.
*we are going to enlist doctor P.*
641 (.)
642 P: j[a
*yes*
643 D: [ja?=
*yes?*
644 P: =krijg ik daar tabletten voor?=
*do I get tablets for that?*
645 =of-
*or*
646 (0.5)
647 D: eh:: ja
*uh yes*
648 ()
649 twee per dag.
*two a day*
650 (0.5)
651 P: twee per dag.
*two a day*

340

652 (.)
653 D: ja=
*yes*

In this episode, the physician again plays an 'open game' by telling the patient explicitly what and why he writes on her record card (lines 561-580). He considers asking a specialist to look at the case, with a mind to the first-mentioned alternative. He goes as far as saying that he is a "layman" in that area (584). The patient, again, claims ignorance and says she leaves it all to him (586-590). But before referring her, he wants to try one other thing - he does not explain what or why, nor even from which of the alternatives considered it follows, just that it involves tablets, two a day - and if that doesn't help, he will consider referring her to the specialist (lines 593-624). After this there follows some repetitions and instructions (not quoted for reasons of space), but the treatment as such is no longer discussed. Again we see in this case a combination of 'announcement' and 'proposal'-like formats, related, so it seems, to 'strong' or 'weak' positions, taken by the physician. But, as we saw, the patient refuses quite explicitly to 'join' in the consideration of the 'weak' possibilities, i.e. by taking stands in the debate of the alternatives. In other words, in these episodes the physician seems to start a 'debate' on diagnostic possibilities and disposal alternatives, displaying his inability to make up his mind on the case. The patient, however, refuses to take a stand on either issue, she just accepts what the doctor ends up proposing.

**4. Disposals As Moves in Extended Negotiations**

Until now I have at least implicitly suggested treating disposal negotiations as relatively isolated episodes, starting with a proposal by the physician. And I have been rather unsuccessful in discovering anything resembling 'negotiations' as ordinarily conceived. In case one, the patient had to be reminded of his 'duty' to react to the proposal, or of the fact that it was a 'proposal' in the first place. In the second and third cases, the announced disposal was simply acknowledged by the patient. And in the last case, the physician presented the patient with alternatives to which the patient showed herself to be reluctant to respond. One might suggest that the physicians who took a 'weak' position, bidding for acceptance or presenting alternatives and displaying insecurity, had special motives for suggesting that the disposal was negotiable. Let us now re-examine the cases to explore where those motives might have their origins.

Taking 'negotiation' in a broad sense, one might say that it starts the moment the patient enters the consulting room. That act already 'proposes' that the patient is in a

state that deserves medical attention in one way or another, that he or she is a legitimate patient. In many cases, of course, the story the patient tells the doctor, and additional elements brought forward later, often only loosely connected to the physician's questions or completely unsolicited, can be seen as a case presentation, as an elaboration of the proposal stated by entering. When we accept this argument, the disposal proposed or announced later by the physician is not a 'first' act, but a 'subsequent' one, in sequential terms. For this reason, we should look at the pre-disposal episodes to discover the 'sequential environment', in a large sense, of the disposal, to explore sequential reasons for the choice of one or another of various disposal formats.

Space prohibits a detailed inspection of all four pre-disposal episodes, so I will have to summarize. In case 1, the patient's story,[3] and especially the many elements he adds to it, suggest that he has entertained two alternative possibilities, some kind of muscle disorder and a persistent cold. He has reported that he has had a patent medicine applied to relieve his muscle ache, but without success.[4] The announcement of the doctor's findings in lines 126 etc. seems to be designed to display its relevance to that earlier hypothesis, which is recovered, so to speak, because the alternative, a strong cold, could not be confirmed by the physical examination. So the proposal is to attack the muscular pain directly, in the implied expectation that when the patient moves easier, the muscular pains will heal automatically. And an additional prescription for nose drops might at the same time relieve some of the symptoms of the 'minor' cold.

Subsequent to the episode cited, the parties discuss the patient's eating habits, triggered by his question about vitamins in line 175. And when the physician writes the prescription and gives his instructions, the patient asks another question, suggesting the air conditioning in the place where he works – a bar – is the real source of the trouble. The physician agrees that this may very well be the real cause of both the persistent cold and the muscular pain. After that, they exchange some rather hilarious complaints about air conditioning generally, and ways to counter its effects at the patient's workplace in particular. Then the consultation ends.

The way the physician 'proposed' his disposal may be seen as a subsequent move in a progression of a rather vague presentation of a complaint, with additional information that suggest two alternative hypotheses, one of which had to be rejected in its strong form, leaving the other as an unexplained problem. That proposal is to cure the symptoms, rather than the disease which is as yet unaccounted for. The 'proposal' strategy may function as a way to co-opt the patient's acceptance of this less satisfactory solution. It is only after the patient himself, in a pre-closing episode, has suggested the basic cause, that the cognitive puzzle can be solved, or at least that a plausible solution is found. So we have a case here where it is the patient who brings in, in a delicate fashion, material that enables the physician to construct his disposal. The latter's role

thus seem to be that of an 'arbiter' for a debate that has been going on in the patient's life world, and a provider of medication. The format of the consultation (Ten Have 1989), however, requires that this game be played furtively, under the cover of an ignorant lay person consulting a professional specialist. As for the other cases, their pre-disposal course is somewhat less complicated.

In case 2 the disposition follows a rather explicit consideration of two alternative diagnoses, on the one hand a cold with coughing, on the other an allergy with wheezing. The first alternative was suggested by the symptoms presented on entering, the second came up somewhat accidentally, when the patient mentioned that her coughing was worse at bedtime. The first alternative was explored by looking into the patient's throat and listening to her lungs, the second by a verbal examination of symptoms and circumstances. The first possibility seems rather weak, but the second is firmly rejected by the doctor (Well I- uhhhhhh I don't think that that's: (1.2) a specific enough: .hh relationship if you really are allergic dust'n feathers .hhhhh it (0.2) It really is a very noticeable thing. (0.4) Th' dut- tih- you (.) byou: the dust flies'n you really- You start to wheeze rather than to cough. – patient's contributions omitted). So the decision is to follow the cough/cold argument, although the complaint does not seem to be taken too seriously. The disposal, in this way, is a kind of 'just for sure' closing of the case. In no way has the patient expressed any opinions or recounted experiences that might be a basis for disagreement with the physician's disposal.

Case 3,[5] starts with the patient requesting an examination of her leg. The leg is examined and it is concluded that it is a muscular complaint (misschien geforcS<.red. 'n keep - *maybe strained one day,* line 99). After the first episode quoted above in excerpt 3a, the patient is questioned on her experiences during her work, after which she refers to various circumstances that seem to be connected with a worsening of the complaints. This leads to an examination of the patient's feet, which results in 'ja hij is niet alleen dik maar hij is ook ontzettend doorgezakt' *(yes it is not only swollen but it is also terribly sagged,* lines 213-214). It is after this diagnosis that the episode about buying shoes, quoted as excerpt 3b, starts. In short, this is a rather straight-forward 'complaint-examination-diagnosis-advice' sequence. The only complications are the phases in the examination, i.e. a physical examination of the leg, a verbal inquiry about symptoms and circumstances, and again a physical examination of the feet, and the 'social' complications of the advice to buy a different kind of shoes, as discussed earlier. The patient is anxious to have the doctor find a solution to her problem (and to be able to continue her work) and she seems quite happy with the outcome.

In case 4,[6] finally, the patient has consulted the doctor about another, acute complaint. The moment that case is settled, she mentions that her foot is causing discomfort. She continues for quite some time to explain how she suffers from it,

while the physician displays his recognition from earlier occasions. At a certain moment he reads from the patient's record card: '.hhh ik heb vorige keer, (0.7) hier gezet op 'vijfentwintig oktober, (0.7) is dit toch niet een ra:re vorm van jicht.' (1 *have last time wri1ten here on* 25 *October isn't this after all a strange kind of gout,* lines 250-255), and. recounts that he had written something similar. So he 'shales' his hypotheses with !lis patient, who seems unwilling to enter this 'game', as she comments on the just mentioned statement with a '.hhikkan 't nie z!<ggen.' (1 *cannot say so,* line 258). After that, she alternates between 'locational' and symptom/circumstances descriptions. The doctor participates briefly in this and examines her feet. It is after some writing that he starts the disposal episode discussed earlier. Again, the pressure from the patient is for a solution to stop the suffering, but she in no way claims any non-experiential knowledge. In fact, she rejects, both earlier and in the episode discussed before, the possibilities offered by the physician to participate cognitively in the 'debate'. She makes it cleat that she is willing to accept anything he proposes, refusing to 'negotiate' what she seems to consider his prerogative and responsibility.

## 5. Conclusion

The four cases explored in this chapter offer examples of some of the ways in which case disposals in GP consultations may be formatted. Three formats were found, in various combinations: Proposals, Announcements and Debates. The patients in these data seemed rather reluctant to join in a more active way in the disposal episodes, i.e. ID *negotiate* proposals and debates. This is in line with Heath's (1992) findings concerning the diagnosis. Heath comments on "an extraordinary 'passivity'" of patients “in receiving news or information concerning their illness" (260-261).

The choice of the formats was shown to be responsive to case characteristics, in sequential terms, concerned with the earlier contributions by the patients, and in terms of whether the disposals were 'strong' or 'weak' decisions, and whether they were strictly medical or had some social implications. Further research is needed to elaborate this framework, and especially to see whether 'real', explicit disposal negotiations can be found and how they ate socially organized through discourse action.

## Notes

1. The disposal of the case, deciding what should be done should be distinguished from the diagnosis, the medical assessment of the current medical condition. On the latter, see Heath (1992). His analysis is compatible with the one presented in this chapter.

2. Cases 1,3 and 4 concern GP consultations recorded in the Netherlands; below the transcript lines in Dutch, rough 'glosses' in English are provided in italic. Case 2 was recorded in the U.K.

3. Quoted in ten Have (1991b:144).

4. Quoted in ten Have (1991b:147).

5. Aspects of this consultation were examined in ten Have (1991a:57-59).

6. Aspects of this consultation, including the 'lamenting' way in which the patient offered unsollicited information, were examined in ten Have (1991a).

**References**

[originally included in the list at the end of the book]

Have, P. ten (1989) 'The consultation as a genre'. In: B. Torode, ed. *Text and Talk as Social Practice*. Dordrecht/Providence, R.I.: Foris Publications: 115-35

Have, P. ten (1991 a) 'The doctor is silent: observations on episodes without vocal receipt during medical consultations'. In: B. Conein, M. de Fornel, L. Quéré, *Les formes de la conversation*, vol 2. Issy-les-Moulineaux: CNET, 1991: 55-76

Have, P. ten (1991 b) 'Talk and institution: a reconsideration of the 'asymmetry' of doctor-patient interaction'. In: D. Boden & D.H. Zimmerman, eds. *Talk and social structure: studies in ethnomethodology and conversation analysis*. Cambridge: Polity Press: 138-63

Heath, C. (1992) 'The delivery and reception of diagnosis in the general-practice consultation'. In P. Drew & J. Heritage, eds. *Talk at Work: Interaction in institutional settings*. Cambridge: Cambridge University Press

Jefferson, G. (1984) 'Notes on a systematic deployment of the acknowledgement tokens "Yeah" and "Mm hm"', *Papers in Linguistics* 17: 197-206

Maynard, D.W. (1984) *Inside plea bargaining: the language of negotiation*. New York: Plenum

Mazeland, H. (1992) *Vraag/antwoord-sequenties*. Amsterdam: Stichting Neerlandistiek VU (also: PhD-dissertation University of Groningen)