Multi-party talk in the medical encounter: Socio-pragmatic functions of family members' contributions in the treatment advice phase

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ABSTRACT

Discourse analytic treatments of medical communication have traditionally centered on dyadic interactions, occurring between a physician and a patient. However, given the increasing complexity of healthcare systems, contemporary medical encounters often involve additional participants, including patients' family members. The present study builds on previous research investigating triadic and multi-party medical encounters — primarily in pediatric and geriatric contexts — and extends it to other specialties (i.e., neurology and rheumatology), which include patients with a wider range of ages — in medical contexts where patients are capable of speaking for themselves. Focusing on audio-recordings of naturally-occurring medical discourse, we explore the ways in which family members establish legitimacy as co-collaborators, drawing on strategies that display knowledge, assume authority, and share responsibility within the interaction. In this way, their contributions help to construct an understanding of the patient's condition and, in many cases, affect the treatment decision-making process.

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In discourse analytic research, the prototype of medical communication is typically presented as a dyadic interaction occurring between a physician and patient. However, as contemporary healthcare systems continue to increase in their complexity (Iedema, 2007), growing numbers of consumers are responding in diverse ways. One strategy used to manage the complexity of navigating a system with various levels of bureaucracy, multiple information sources, and complex treatment plans is to bring a family member along to the medical encounter. Halkowski (2011) has called for research on medical interactions that extend beyond the dyad and take into account multiple participants — which represent the reality of a growing number of medical interactions: "One way [medical communication] research is widening out is by paying more systematic attention to the fact that a 'doctor-patient' encounter is often a 'doctor-patient-patient family member' encounter, and that this move from two to three parties qualitatively transforms any encounter" (329).

In the present study, we explore the linguistic and discursive practices participants — physicians, patients, and family members — use in multi-party medical encounter interactions to collaboratively establish and make sense of patients' health and wellbeing. Our primary focus is on the family members' contributions, as we examine the discursive means they use to display knowledge, assume authority, and share responsibility with others in the interactions. As we discuss below, previous research on triadic and multi-party medical encounters has focused predominately on pediatric and geriatric contexts. In

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these contexts, Halkowski (2011) notes that "'speaking about' and 'speaking on behalf of' defines the discursive practices that constitute the interactants' relations to each other" (329). Our study offers a complementary approach, adding to this line of research, to demonstrate the ways in which family members speak *alongside* patients in medical contexts where patients are able to speak for themselves.

In order to situate our study, we provide a review of relevant empirical research on multi-party medical encounters, which shows that family members assume various roles as they speak *on behalf of*, *for*, and *about* patients. Next, we examine key ideas associated with displays of knowledge in social interaction. Following this background, we present our analysis, which examines the ways in which family members speak *alongside* patients, establishing legitimacy as co-collaborates in the interactions. Further, we explore the discursive strategies family members use to display knowledge, assume authority, and share responsibility in order to co-construct an understanding of the patient's condition and, in some cases, affect the treatment decision-making process.

1. Background

1.1. Triadic/multi-party medical encounters

The body of literature on triadic or multi-party medical encounters is diverse and extensive. Empirical studies examining the effects of a third (or fourth) person in the examination room come from a variety of disciplines such as, medicine, medical anthropology, sociology, and applied linguistics, among others (Cabral et al., 2014; Laidsaar-Powell et al., 2013; Wolff and Roter, 2011). Triadic medical encounters research has primarily focused on only two medical contexts: geriatrics and pediatrics. It is not surprising that research in this area has focused on these two settings, given the cognitive, physical, and social abilities that differentiate these two patient populations from others. In geriatric settings it is much more expected that family members or companions accompany older patients given their potentially diminished cognitive, oral, aural, and physical abilities (Adelman et al., 1987; Coupland and Coupland, 2001; Ishikawa et al., 2005). Similarly, in pediatric settings mothers or fathers (and/or grandparents) accompany their children and assume greater interactional responsibility given children's still developing cognitive, social, and linguistic abilities (Nova et al., 2005; Stivers, 2001; Tates et al., 2002). Thus, in both settings the level of autonomous control patients have over their own health decisions may be unclear; consequently, the need for a third party to speak *on behalf of* the patient may, at times, be necessary given the abovementioned limitations associated with older and younger patients.

In the present study we expand the scope of this research to examine triadic medical encounters that occur in specialties other than geriatrics and pediatrics. With other types of clinical specialties (i.e., Neurology, Rheumatology), it is assumed as well as empirically documented (Byrne and Long, 1976; Heritage and Maynard, 2006; Mishler, 1984), that adult patients generally attend medical encounters alone, speaking one-on-one with their physicians. Moreover, and in contrast to geriatric and pediatric settings, it is also assumed that patients maintain full autonomous control over their healthcare and decision-making. Through examples from our dataset we will present several medical encounters in which family members attended the sessions with their spouses and adult children. The family members participated in the interactions, speaking *alongside* patients, even when their presence was not necessarily needed or required. Presented with this reality, it becomes necessary to examine the ways in which family members share the verbal workload with patients to jointly construct an account of the patient's health.

In geriatric settings, several triadic medical encounter studies have found that patients' companions assumed a variety of roles or different "communication modes" (Hasselkus, 1992) during interactions (Adelman et al., 1987; Beisecker, 1989; Ellingson, 2002; Hasselkus, 1992; Ishikawa et al., 2005). For example, using empirical data from 12 medical encounters, Beisecker (1989) found that patients' companions played three different roles: *watchdog* (provided further information for doctor, clarified or obtained information from physician, challenged the truth of information offered by patient), *significant other* (provided physician feedback about companion's role, often causing the physician to switch to third-person address form), and *surrogate patient* (took over patient role, interrupted patient, answered questions for patient, and provided unrequested information to health care provider). Hasselkus (1992) also found that patients' companions assumed different "communication modes" (288). In her study analyzing 40 triadic medical encounters, she found caregivers' contributions analogous to that of an interpreter and showed how they took up the interpreter role in three primary ways: *facilitator*, *intermediary*, and *direct source*. As facilitator, the caregiver served as translator, using various strategies (e.g., clarification, correction) to address patients' linguistic features that were impeding interactions. As intermediary, which occurred in a majority of the encounters, caregivers were actively involved in providing information, knowledge, and context about the patient's situation (295–296). Commonly, caregivers performed the intermediary role through answering and asking questions and providing further information. In the direct source role, caregivers became direct primary sources of information for physicians and, as a result, triadic interactions evolved into dyadic interactions between caregivers and physicians (see also Karnieli-Miller et al., 2012).

Other multi-party geriatric medical encounter studies have also explored the concept of direct source (Hasselkus, 1992), coalitions (Coe and Prendergast, 1985) or confederations (Coupland and Coupland, 2001), as variously termed in this body of literature. During triadic interactions, coalitions are formed when two participants adopt a common alignment or position to achieve an aim that is different from or excludes the third participant. Both Hasselkus (1992) and Coupland and Coupland (2001) demonstrated that family member-physician coalitions formed, resulting in patients being spoken *about*. Coupland and Coupland (2001) explored how being talked *about* was used to both positive and negative effect on patients. In one

example, the family member and physician joined forces to "talk the patient up" (97) in an effort to improve her morale and in the second example the family member and physician aligned over several turns of talk to negatively evaluate the patient (the family member's mother) using stereotypical and age-prejudicial terms (99).

In line with Beisecker (1989), other studies have also explored the concept of surrogacy as family members served as patient substitutes to speak *for* or *on behalf of* patients during medical encounter interactions (Coupland and Coupland, 2001; see Mazer et al., 2014 in an oncologic setting). In geriatric settings, the surrogate role is not surprising given the previously mentioned characteristics (e.g., hearing loss, language impairment) potentially found in this patient population. Assuming the surrogate role, Beisecker (1989) showed how patients relied on companions to produce and verify information, thus "acting as voice and advocate for the patient" (63). Similarly, Coupland and Coupland (2001) illustrated how a son discursively assumed the surrogate role to report and request information on behalf of his mother and voice her personal experiences and concerns. Interestingly, Mazer et al. (2104) made a distinction between "surrogacy" and "pseudo-surrogacy" when categorizing companions' contributions. They utilized the term "pseudo-surrogacy" to describe instances when companions "spoke as if the patient were not in the room or unable to speak for him/herself"[1] (38). Specifically, and in line with other studies' use of the term "surrogacy", they demonstrated how companions took up the pseudo-surrogate role answering questions addressed to patients and describing patients' values or experiences as first-hand experiences. As their study took place in a setting where patients were capable of speaking for themselves, this concept of pseudo-surrogacy has important implications for our study.

1.2. Displaying knowledge in social interaction

Our study is also influenced by previous scholars who suggest that knowledge, and the rights and responsibilities associated with it, has long been considered a socially constructed phenomenon that is shaped by language and managed by speakers/hearers in conversation (Heritage, 2013; Fox, 2001; Hill and Irvine 1993a,b; Stivers et al., 2011). Concerning displays of knowledge, Stivers et al. (2011) explain that "at issue is whether we have epistemic *access* to some state of affairs, but also how *certain* we are about what we know, our relative *authority* and our differential *rights and responsibilities* with respect to this knowledge (italics in original; 3). It is common, especially in institutional contexts such as medical encounters, that relative authority and differential rights and responsibilities to know lead to knowledge asymmetry or epistemic asymmetry in conversation (Drew, 1991; Heritage and Raymond, 2005; Sidnell, 2012; see Ariss, 2009; Pilnick, 1998 for medical contexts).

Stivers et al. (2011) discuss three primary dimensions of knowledge — epistemic access, epistemic primacy, and epistemic responsibility — that interactants treat as salient in conversation (9). In social interaction speakers and hearers manage these knowledge dimensions, holding one another accountable, so that social norms such as agreement, alignment, and affiliation can be realized (Heritage and Raymond, 2005). Exploring each of these dimensions in turn here, epistemic access relates to an individual's knowledge state in absolute terms; in other words, knowing versus not knowing. During interactions speakers continuously manage knowing and unknowing interlocutors as they come to agree on who has and does not have access or "epistemic access congruence" (Stivers et al., 2011 10). Moreover, interactants demonstrate cooperation in interactions by making claims only about which they have sufficient access and also avoid speaking about some state of affair about which they have no knowledge (i.e., Grice's 1975 maxim of quality). Although access to knowledge is conceptualized as binary — knowing or not knowing — interactants choose to display their knowledge through varying degrees of certainty and can differentiate between direct and indirect access (see below for further discussion of direct and indirect sources of knowledge). To do so, interactants rely on a variety of linguistic resources, such as "lexical certainty markers" (e.g., *I think*, *maybe*, *probably*) (Kärkkäinen, 2003), epistemic downgrading (e.g., evidential verbs, tag questions) (Heritage and Raymond, 2005) and reported speech (Clift, 2006; Fox, 2001).

Whereas epistemic access deals with issues of knowing versus not knowing in absolute terms, epistemic primacy deals with *relative* knowledge and *relative* rights to knowledge. This relativity is made salient in conversation as interactants orient to "asymmetries in their rights to know about some state of affairs as well as their rights to tell, inform, assert, or assess something[2]" (Stivers et al., 2011, 13). Consequently, relative states of knowledge or "distributions of knowledge" (Sidnell, 2012) can cover a range of situations: speaker A has absolute knowledge while speaker B has no knowledge; both speakers A and B have equal knowledge; as well as every circumstance in between (Heritage, 2012). Interactants demonstrate cooperation by making claims only when they have sufficient knowledge and rights to do so and interactants with more comprehensive knowledge have primary rights to make claims and assessments related to a particular domain (Stivers et al., 2011; see also Drew, 1991; Heritage and Raymond, 2005; Stivers, 2005c). To negotiate epistemic primacy in and through conversation, interactants rely on a variety of linguistic and discursive resources as well as sequential organization of turns-at-talk to take up epistemic positions.[3] In addition to these resources, social roles (e.g., mother, nurse) as well as interactional roles negotiated locally may also play a part in establishing epistemic primacy in interactions (Drew, 1991; Stivers et al., 2011).

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[1] Mazer et al. (2014) considered "surrogacy" to occur in instances when the patient lacked the capacity to make medical decisions, such as with coma or dementia.

[2] Our interpretation of epistemic primacy is that it is related to Labov and Fanshel's (1977) differentiation between A-events and B-events, Pomerantz's (1980) Type 1 knowables and Type 2 knowables, Kamio's (1997) discussion of "territories of information" and Heritage's (2012) use of the term *epistemic status*.

[3] Heritage (2012), Heritage and Raymond (2005), and Sidnell (2012) provide good overviews of the language and sequence organization resources utilized to negotiate epistemic primacy in interactions.

The third area Stivers et al. (2011) explore related to displays of knowledge is epistemic responsibilities. In the same way that interactants have access and relative rights to knowledge, they also have particular *responsibilities* with respect to their knowledge. While knowledge access and relative rights to knowledge are dealt with rather straightforwardly, responsibilities related to knowledge deal with the "messier" work of what individuals actually *do* with knowledge and how they choose to display it or not. At this intersection of knowledge and responsibility, Hill and Irvine (1993a) acknowledge the important role of agency. They suggest that "to interpret events, to establish fact, to convey opinion, and to constitute interpretations as knowledge — all these are activities involving socially situated participants, who are agents in the construction of knowledge as well as being agents when they act on what they have come to know, believe, suspect, or opine" (Hill and Irvine, 1993a, 2). Individuals exercise agency and accept responsibility (held responsible) for content (i.e., actual knowledge, claim) and form (i.e., linguistic resources). As well as accepting responsibility for what is said and how, speakers/hearers are (held) responsible for making use of what they know about their interactants in designing their turns and knowing what is and has been established as common ground between interactants (Stivers et al., 2011, 18).

A final consideration for epistemic responsibilities concerns the related issues of sources of knowledge and the distribution of responsibility. In conversation, individuals assume responsibility and are held accountable for their sources of knowledge — direct, first-hand knowledge or indirect knowledge, which may be attributable to another speaker or outside source (e.g., reported speech, Tannen's (1989) constructed dialogue). Thus, indirect knowledge responsibility may be distributed across multiple sources, who may or may not be co-present in the conversation.

Medical encounters have served as a rich context in which to explore displays of knowledge and have long been viewed as a type of institutional interaction in which knowledge asymmetry has been unavoidably at play. The asymmetrical dimension of medical encounters has been characterized by favoring physicians' biomedical knowledge and technical expertise over patients' lay knowledge and experience (Frankel, 1984; Heath, 1992; Heritage and Clayman, 2010; Maynard, 1991; Mishler, 1984; ten Have, 1991). Further, previous research has demonstrated how these differences in epistemic authority are made especially relevant in the diagnostic and treatment recommendation phases of the medical encounter (Heath, 1992; Landmark et al., 2015; Lindström and Weatherall, 2015; Peräkylä, 1998, 2002). In the diagnostic phase, epistemic authority is tipped in favor of physicians, who are availed of various resources (e.g., medical knowledge, diagnostic reasoning, professional identity) to make diagnoses, meanwhile patients remain fairly passive and nonresponsive (Byrne and Long, 1976; Heath, 1992; Peräkylä, 1998, 2002). In the treatment phase, physicians and patients tend to share authority as patients assume a more active role and as both participants orient to and assume responsibility for decisions (Koenig, 2008, 2011; Stivers, 2005a).

The treatment phase is of particular relevance in this study as the extracts we have selected come from this phase of the medical encounter. Given the negotiated nature of this phase it is important to explore how participants, including third parties, utilize differential knowledge bases and take up different epistemic positions to reach and agree on treatment. Therefore, we draw on concepts presented in this section to explore the linguistic resources and discursive practices family members utilize to display knowledge and assume authority and responsibility. With this study we extend this line of inquiry, which has primarily focused on dyadic physician–patient interactions (e.g., Landmark et al., 2015; Lindström and Weatherall, 2015), by focusing on how family members' draw on epistemic resources to contribute to interactions.

2. Data and method

The data analyzed below come from a larger study (Fioramonte, 2014), which focused on the co-constructed and negotiated nature of the treatment recommendation phase of medical encounters. The study was conducted at a research-intensive university in the southeastern United States. At the university, medical education is a key academic mission; therefore, all medical encounters occurred in a medical teaching context. In this teaching context, physician residents and fellows worked alongside attending physicians to care for and treat their patients. The physicians who participated in the study were three residents, two fellows,[4] and four attending physicians. All interactions occurred with unique patients; family member descriptions are provided below.

The medical encounters took place in two outpatient clinics affiliated with the university. Two medical specialties were included: Neurology and Rheumatology. Patients presented with a variety of chronic illnesses (e.g., arthritis, headaches, limb pain) and they visited the clinic for both new and follow-up visits. The patient population represented a wide range of ages — 30–70 years old.[5] Given these medical encounter characteristics, the present study expands the scope of the triadic/multiparty talk literature in important ways. That is, the medical encounters examined here occur in medical specialties other than geriatrics and pediatrics and the patient population represents a wider age range, not only children and elderly.

The primary data for the study were audio-recordings of naturally occurring medical encounters interactions. The decision to use audio, in lieu of video, in the original study was made due to the increased logistical challenges related to the use of video as well as privacy concerns for the patients. The larger study consisted of 28 transcribed interactions. In addition to the

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[4] In our Analysis section, no differentiation is made between resident and fellow; they are both called "resident" and labeled as "RES" in the excerpts.

[5] Patients completed a post-medical encounter survey, which served as an additional data source. Basic demographic data (e.g., age, gender, education, etc.) were collected in the survey. The purpose of this survey was to assess patients' perceptions of the medical encounter, including treatment recommended.

audio-recorded interactions, one researcher observed all medical encounters and took ethnographic field notes. This methodological approach, combining naturally occurring medical interactions with ethnographic data, creates an interpretative process for contextualizing the micro-structures of talk. Informed written consent was obtained from all participants prior to recording the interactions. For purposes of anonymity, participant names and locations (e.g., hospital or clinic names) have been replaced with pseudonyms.

In this study it was often the case that an additional individual joined the patient in the examination room in the medical encounter. In one instance a nurse accompanied the patient, serving as her advocate, but most often it was a patient family member who participated in the visit. In nearly one-third, or eight out of 28 interactions (29%), family members accompanied patients in the examination room. Table 1 displays characteristics of these eight interactions, including patient's age and gender, family member's relationship to the patient, patient's diagnosis, and medical specialty. Family members represented are: wife, husband, father, mother, and daughter. In all but one of the interactions, family members actively participated in the unfolding conversation.[6]

Table 1
Interactions with family members.

Interaction #	Patient's age	Patient's gender	Family member	Diagnosis	Medical specialty
RHOI004	60—69	Male	Wife	Rheumatoid arthritis	Rheumatology
NEOK001	30—39	Male	Wife	Lupus	Neurology
RHOI002	60—69	Female	Husband	Osteoarthritis	Rheumatology
RHOI008	60—69	Female	Husband	Lupus	Rheumatology
RHCG008	Unknown	Female	Husband	Rheumatoid arthritis	Rheumatology
NESG002	Unknown	Male	Father	Undiagnosed	Neurology
RHCG004	50—59	Female	Mother (adoptive)	Lupus	Rheumatology
RHCG002	40—49	Female	Daughter	Rheumatoid arthritis	Rheumatology

Note: In the two instances where "Unknown" is indicated the patient either did not complete the survey or did not complete the demographics section of the survey. The patient's approximate age in interaction RHCG008 is 70—79 and the patient's approximate age in interaction NESG002 is 50—59; these approximations are based on observations by one of the researchers.

It is well documented that a microanalytic approach, using the methodological and analytical tools associated with Conversation Analysis (CA), has been productively used to examine the intersubjectivity and social activities achieved through detailed analyses of the sequential organization and turn-taking management of dyadic and multi-party medical encounter interactions (Davis, 2010; Heritage and Maynard, 2006; Jones, 2015; Stivers, 2002a, 2002b, 2005a, 2005b, 2006, 2007). While many of these CA studies have drawn upon pragmatic concepts (e.g., asymmetry, power, speech acts) to inform their analysis, few scholars "explicitly mention using pragmatics as a method of inquiry" (Martin, 2014, 494; see also Davis, 2010). In this paper, we attempt to counter this trend as we bring together concepts relevant to both pragmatics and discourse analysis to adopt a functional approach to the analysis of discourse in context.

Our analytical approach is centered on the notion that interlocutors take up different discourse roles (Sarangi, 2010) or "relational configurations" (Coupland and Coupland, 2001, 85) through the gradual progression of talk as participants engage and make sense of a social experience. These different discourse roles become manifest as participants construct varied footings or alignments between one another as well as between themselves and what is said (Gordon, 2015). As Goffman (1981) tells us, "a change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance. A change in our footing is another way of talking about a change in our frame for events" (128). A productive way for analyzing framing and shifts in footing is to focus on the verbal and non-verbal cues participants use to indicate a particular understanding of a situation (see also Gumperz, 1982 for the related notions of "contextualization cues" and "speech activity").

Following the discourse analytic approach taken in Coupland and Coupland (2001), we draw on the concepts of framing and footing to analyze the discursive strategies patients, physicians, and, in particular, family members use to enact different discourse roles. For example, a family member may assume the role of information provider (Beisecker, 1989; Hasselkus, 1992) in one discursive frame but shift to a pseudo-surrogacy role (Mazer et al., 2014) in an alternative frame, assuming the responsibility for answering questions directed to the patient. And while many of the previous multi-party studies acknowledged that family members' might play multiple roles throughout a single interaction, the studies did not demonstrate how these shifts over time were achieved (Beisecker, 1989; Ellingson, 2002). Thus, through this discourse analysis we attempt to demonstrate ways in which family members take up different discourse roles or relational configurations, establishing themselves as legitimate co-collaborators in medical encounter interactions.

3. Analysis

Our analysis found that family members' utterances functioned in the following primary ways: to ask questions, respond to questions, provide information, make suggestions, and make evaluations. To demonstrate these different functions, we

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[6] In interaction # RHCG002 the daughter did not verbally participate at all during the interaction.

purposely selected multi-party interactions that are different from one another, as a primary aim of our analysis is to highlight and explore variation. In this section, we start with a short, straightforward example demonstrating how a family member speaks *alongside* the patient on medical matters. Two longer, more complex examples follow, in which one demonstrates how a family member assumes a level of authority to control both the topic and flow of the interaction and the second demonstrates how a family member shares responsibility with the patient to provide a comprehensive picture of the patient's health and social wellbeing.

3.1. Displaying medical knowledge through question responses

Physician-patient interaction studies have demonstrated that medical encounters consist of a series of question-response sequences (Heritage and Robinson, 2006; Robinson, 2003) in which physicians ask a myriad of questions in a variety of domains (e.g., physical, factual, emotional), to which the patient typically responds. In multi-party encounters, patients remain the preferred responders, as they are the more accountable party (Gill, 1998; Halkowski, 2011), however, as our data demonstrate, family members also contribute by responding to questions posed by both physicians and patients.

In our data, patients' family members primarily respond to questions that seek factual information or are about practical matters of the visit. Most frequently, they respond to questions on the topic of medications. Specifically, their responses relate to medications' effects on symptoms, patient's usage patterns, and the need for refills. Family members' responses add to patients' previous responses, help clarify patients' responses, and at times, directly answer questions posed to the patient by the physician.

The first extract is a short, concise example that demonstrates how a patient and family member work collaboratively to construct a response to the physician's question. Moreover, the interaction shows how the family member contributes important information, which, in turn, affects the physician's course of action in prescribing a medication. The interaction, a follow-up visit with a female patient previously diagnosed with rheumatoid arthritis, occurs in the Rheumatology clinic. The patient's husband accompanies her. During the visit a CAT scan is ordered. The extract below occurs immediately following the treatment advice phase as the resident poses a practical question about the patient's current medications and the need for refills. The attending physician has already left the examination room.

Extract 3.1 — RHCG008 — Husband

575:	RES:	do you need refills for your: steroids?
576:	(1.5)	
577:	PAT:	I I don't think so do I ne- need refills
578:	(1.0)	
579:	PAT HUS:	**the only thing the only thing is that Prednisone is a thirty day**
580:		**refill instead of a nin(h)ty day refill**
581:	RES:	okay so I'll change it ah it was probably because did I do:=

The resident's question about the need for a prescription refill opens the sequence in line 575. The use of the second person singular forms *you* and *your* in the question formulation selects the patient as the preferred responder, as evidenced by the content and context (e.g., referring to the patient's prescription) (Coupland and Coupland, 2001; Stivers, 2001). After a pause, the patient provides a response that signals some uncertainty: she constructs her response using epistemic mitigation (Kärkkäinen, 2003) to state she does not need a refill and follows this immediately with the question *do I ne- need refills*. Reflecting her uncertainty about a need for refills, this question — *do I ne- need refills* — invites another participant, most likely her husband, to (dis)confirm the need for a prescription refill (see Sidnell, 2012). In this way, her question functions as an involvement strategy — involving her husband to help her make a decision. However, her husband does not immediately take up this implicit request for assistance as the patient's utterance is followed by a long pause, opening space for any interactant to fill it. Following a second of silence, he provides a response in line 579. He begins his turn by repeating the clause, *the only thing*, which indicates that what follows is in addition to, or different from, his wife's response. After this preparatory move, he states that her prescription for Prednisone is for thirty days, not ninety days. The formulation of this response functions on a transactional level by providing important, concrete information about the "state" of the prescription. Moreover, this utterance serves to expand on his wife's response, and while he contradicts her *I don't think so* response, he does so using a hedging strategy (*the only thing*). Additionally, this strategy directs the topic of his response to the prescription and away from his wife, thus minimizing the contradictory force while also providing the resident the information she needs. The resident takes up this additional information and uses it in her next turn, stating she will change the prescription, presumably to a 90-day refill.[7]

This response to the physician's question about a need for refills demonstrates that the husband has specific knowledge about one of his wife's medications. In this way, he displays his epistemic access to this information. This is not an isolated incident, as on several occasions throughout this interaction, the husband displays additional detailed

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[7] Through the resident's turn we can find another interactional meaning for the husband's response: it implicitly accomplishes a request for a prescription with a longer refill (90 days instead of 30 days), potentially eliminating a bureaucratic inconvenience.

medical knowledge about his wife. He demonstrates this knowledge by responding to questions, making evaluations, and asking questions of both the physicians and his wife. Several of his questions and responses reveal an intimate knowledge of the patient's medical condition. Briefly, an example of this occurs several turns prior to Extract 3.1 when the patient's husband is able to put a numeric value to his wife's blood oxygen level (*they checked her blood oxygen level it was 81*). Additionally, he shares how long his wife has had rheumatoid arthritis (twenty years), how long ago she stopped smoking (twenty five years), and details about a surgery she had in the past. Although there is insufficient space here to analyze in detail what each of these interactional contributions accomplishes, collectively they serve to position the husband as a participant who has epistemic access to information about his wife's health and lifestyle and is willing to share it. In this way, he serves as an important resource as he enacts an information provider role — similar to Beisecker's (1989) *watchdog* role or Hasselkus' (1992) *intermediary* communication mode — to actively and collaboratively participate in the interaction. Thus, this example demonstrates how a family member serves as a legitimate contributor, speaking *alongside* the patient to make contributions in a straightforward manner on practical matters associated with his wife's healthcare.

3.2. Assuming authority by asking questions

As noted above, questions serve an essential discursive function to obtain vital health, symptomatic, and medication information about the patient in order to inform and progress the medical encounter. In the medical encounter, physicians typically ask questions, and patients or family members typically respond. However, in our data, patients and family members also ask questions. In fact, family members' questions are posed to both physicians and patients. Overall, the data demonstrate that they ask questions about medications (e.g., purpose, interactions, administration, effect on symptoms), patients' conditions, medical tests and labs, communication with the patient's primary physician, and practical issues, such as next appointments. In this section, we present an interaction showing how a family member's discursive strategy to ask questions influences, and arguably controls, the direction of the interaction. Moreover, the examples demonstrate how a third party participant's use of questions can work to both inform and directly affect treatment decisions.

The next several extracts come from the same interaction. They come from a follow-up visit at the Rheumatology clinic. The female patient, diagnosed with lupus, is accompanied by her husband. She has been prescribed the medication Dapsone, used to reduce itching and redness of the skin. The first extract occurs early in the interaction. Prior to line 65, the interactants were discussing an over-the-counter product the patient was using to help calm her itchy skin. The topic is concluded when the patient's husband provides a negative evaluation of the product and the resident suggests she stop using it temporarily to assess its effect on her condition. A change of topic is initiated in line 65 as the husband takes a turn to open up discussion on his wife's diagnosis.

Extract 3.2 — RHOI008 — Husband

59:	PAT HUS:	that stuff ain't ain't helping ya babe
	(Resident's turn removed)	
62:	PAT:	(kinda) kinda quite the stuff an see what happen
63:	FEL:	yeah because you can start it all the time right?
64:	PAT:	yeah
65:	PAT HUS:	**what about what about what about e- sh- the last three times**
66:		**we've been here she's had no clinical signs of uh of the uh**
67:		**lupus**
68:	PAT:	[lupus
69:	RES:	right
70:	PAT:	the only thing is
71:	RES:	[no complaining
72:	PAT:	the- these red spots they're staying
73:	RES:	right an did you see the::::
74:	PAT:	when I wash my face

With the turn that begins in line 65, the husband's question serves two main functions. In the obvious sense it works to ask about her diagnosis and whether in fact she still has lupus. Secondly, his question moves the medical encounter into the physical examination phase. Hereafter, the resident and patient join in, pick up the discussion, and continue a dyadic interaction as the resident completes the physical exam (interaction not shown).

Similarly, in line 180 below (several minutes later in the interaction), the patient's husband again uses a question to change topic. In this instance he changes topic to initiate conversation on the treatment for his wife's condition going forward. In this way, the family member's question actually initiates and moves the interaction into the treatment advice phase. In our dataset this represents a very unusual move; in the majority of instances, physicians are the participants who initiate the treatment advice phase.

180:	PAT HUS:	**so we're we're gonna get a refill if you want her ta stay on it**
181:	RES:	okay so let me talk to the boss here uh see what he thinks cuz I'm
182:		not so bottom line you didn't see an improvement from the
183:		medicine
184:	PAT:	not not in my skin

These two examples demonstrate how the husband initiates questions about his wife's diagnosis and her treatment. Structurally, the questions work to reframe the conversation from one topic to another and interactionally they work to establish the husband as a knowledgeable and active participant early in the interaction. These instances are followed by the extract below, which shows the joint treatment recommendation phase,[8] arguably a crucial point in the medical encounter. Immediately prior to the extract shown below, discussion between all four participants (patient, husband, attending physician, and resident) centered on the redness of the patient's skin and whether she was responding to the Dapsone medication. The husband brings discussion on this topic to a close with the question in line 401.

401:	PAT HUS:	**you gonna bump her up to two two a day whatdya think**
402:	ATT:	two a day yeah
403:	PAT HUS:	two a day
404:	ATT:	an it doesn't
405:	PAT HUS:	he's going to bump you up two two pills a day
406:	ATT:	so we're going go up to fifty right
407:	PAT:	<oh> <my> <god>

Formulated as a declarative question, the husband uses an informal idiomatic expression − *bump up* − to propose a recommendation to modify the dosage of his wife's medication going forward.[9] With this proposal, he assumes a level of responsibility to ask a question on behalf of his wife. Moreover, his proposal to increase the medication dosage displays a level of knowledge used to tilt the balance of expertise vis à vis the physicians as he moves from the lay to the medical world (Candlin and Candlin, 2002; Sarangi and Clarke, 2002). However, he hedges this temporarily-assumed expertise, deferring to the medical professionals by seeking their endorsement[10] for the proposal, using the question *whatdya think*. As a candidate next speaker, the attending physician offers his endorsement, stating that the dosage will be increased to *two a day*. The husband and attending physician volley turns three more times (lines 403–406), confirming the dosage increase.

While the physician and husband agree to this treatment proposal, the patient does not immediately participate in the decision-making process. It is not until line 407 that she joins the discussion to express her displeasure, or surprise, at increasing the dosage of her medication. She exclaims *oh my god* to the decision just made on her behalf. Her word selection, coupled with the prosodic choice to emphasize each word with a slow, steady pace suggest that she is displeased, or at least taken aback, with the decision to increase the dosage. This interpretation is supported by the fact that on previous occasions in the interaction she uttered expressions that suggested a dislike for taking medication (e.g., *long's it no pill*; *yeah I I don't like the Plaquenil*). Consequently, faced with this decision to increase the medication dosage she makes it known she is not happy. However, the patient's unfavorable assessment is not taken up either by the attending physician, her husband, or the resident, to further explore the reason for this affective response. Instead, the attending physician changes topic in the next turn to the patient's recent lab values (not shown here).

Similar to the husband's contributions in Extract 3.1, the husband here also makes contributions within the medical domain on the topic of the patient's medication, as well as her lupus diagnosis. However, in contrast to the previous extract we see that with each contribution this husband achieves the interactional effect of reframing the conversation back to the topic of diagnostic and treatment issues. Moreover, he does so not by making statements or claims, but rather by using multiple questions to the physicians that serve to control the topic and direction of the interaction. In each instance, the physicians comply with this participation frame as they orient to the topic changes initiated by his questions, taking up each in turn. In this way, his contributions (i.e., questions) afford him a level of responsibility and authority to control the flow of the interaction. Thus, these various discourse strategies of questioning, reframing, and topic control demonstrate how the husband takes up a more independent position in the interaction (Coupland and Coupland, 2001, 96). Rather than collaborating and speaking *alongside* the co-participants, he adopts a more dominant position and assumes this authority and responsibility to consequential effects for treatment planning.

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[8] We use the term "joint" to refer to the treatment advice phase that occurs when both resident and attending physician are in the examination room.

[9] Neither physician made this treatment recommendation to increase the dosage to *two a day* anywhere previously in the interaction.

[10] According to Stivers, Heritage, Barnes, McCabe, Thompson, and Toerien's (2017) analysis and categorization of different treatment recommendation formulations and the social actions that they perform, treatment *proposals* invite endorsement or collaboration (p. 14), allowing for a decision to be made together.

3.3. Sharing responsibility by providing information

In addition to responding to and asking questions, family members also contribute to the unfolding medical encounter by providing information.[11] Our analysis of the various functions of family members' utterances reveals that providing information occurs most frequently. Family members provide additional information on a wide variety of topics: patients' symptoms and conditions, medications (quantity, type, effectiveness), lifestyle, and visit purpose, among other topics.

While the examples presented thus far have demonstrated how family members assume verbal responsibility to make contributions in the medical domain and on factual, practical matters associated with the patients' health, in this section we build on these examples to show how a family member assumes additional responsibility as he provides information in both medical and social realms. Additionally, the examples will show how the family member's contributions work to not only complement the patient's responses but also perform the additional work of providing information that the patient was unclear about or left unanswered. In this way, the additional information provided positions the family member as someone who assumes the responsibility and authority to speak *alongside* and *on behalf of* the patient, helping to present a complete picture of the patient's condition.

This interaction takes place in the Neurology clinic as a male, accompanied by his father, presents as a new patient with lower extremity pain and an undiagnosed condition. The following extract occurs during the treatment advice phase as the attending physician delivers her recommendation to run various neurological tests (not shown) and to prescribe a topical pain reliever.

Extract 3.3 — NESG002 — Father

157:	ATT:	an also we can prescribe to you creams topicals do ha- do you use
158:		any topical preparations (0.5) I would not increase the Gabapentin
159:		dose
160:	PAT FAT:	[**no he doesn't have any**
161:	ATT:	he's falls half a a- a- fall asleep now I would not increase that I
162:		would probably use something topical
163:	PAT:	something th- th- daddy that medication th- it's not I'm not gettin
164:		I'm I'm I I
165:	PAT FAT:	**you're not getting any topical medication no**
166:	PAT:	no an I'm but I'm not getting any ah relief from from pain from
167:		pain that those pil- tha- what I take now (does that)
168:	PAT FAT:	**Neurontin**
169:	PAT:	yeah
170:	PAT FAT:	**Tramadol**

The opening turn serves as the attending physician's treatment recommendation. She designs her recommendation as a pronouncement, stating what she would and would not prescribe to control the patient's pain (Stivers et al., 2017). Mid turn she poses a question — *do you use any topical preparations?* While the son has epistemic primacy to the answer to this question, it is the father who takes the floor, assuming epistemic responsibility, to provide a direct response to this question. In answering on his son's behalf, he references his son using the third-person pronoun *he*. In the immediate next turn (line 161) and likely in response to this turn design, the physician maintains this participation frame, shifting to the third-person reference and begins to speak *about* the patient.

In line 163 the patient joins the medication discussion but provides a rather incoherent response. The father appears to treat his son's turn as a question, telling him something he should already know, which is that he is *not getting any topical medication*. Importantly, the son offers additional details about his current medications stating that they do not provide any relief from pain. Similar to the previous examples, this sequence demonstrates how a family member contributes to a discussion about treatment. In this example, the father's contributions work to manage this brief discussion as he answers questions posed by both the physician and his son and in so doing display his detailed knowledge (i.e., epistemic access) on the topic.

In the next turn, which occurs immediately after the sequence above, the attending physician picks up on the patient's "not getting any relief from pain" utterance to reframe the conversation. She asks the patient what his pain level is (on a scale of one to ten).

171:	ATT:	listen how much is your pain right now
172:	PAT:	my pain is uh: (0.5) uh:::
173:	PAT FAT:	**you said you said five early**
174:	PAT:	[five
175:	ATT:	but
176:	PAT:	but it goes up real high…

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[11] The distinction between providing information and responding to a question is not always straightforward. In instances where a question is used to initiate the sequence, we classified family members' turns as providing information (as opposed to responding to a question) when the question was already directly answered. In this way, the information provided aids to clarify, describe, elaborate, and — in some instances — confuse the situation.

The physician uses a second-person reference here, which is appropriate given that emotional and physical feelings and levels of pain are within the patient's domain. In line 172, having epistemic access and primacy over his current pain level, the patient orients to the physician's question and begins to answer it but leaves it unfinished. His father then takes the floor to aid his son in answering the question. He formulates his response using constructed dialogue (Tannen, 1989) stating *you said you said five early*. Here, it is relevant to point out that, at an earlier stage in the medical encounter, during which the attending physician was *not* present, the resident had asked the patient to report his pain level. It is interesting to note that the father had also provided a response — instead of the patient — in this earlier instance. However, at that earlier point in the interaction, he had reported that his son's pain level was *eight*. Interestingly, during this sequence neither the patient nor the resident disputes or modifies this new pain level of *five*, in spite of the inconsistency of the father's responses to the same type of question.

In not fully completing his response, and instead ending his turn with a lengthened filled pause, the son relinquishes his epistemic rights to another participant. The father then takes the floor, and in turn, assumes epistemic responsibility to provide a response to the pain level question. However, in using the *you said* construction, the father ascribes knowledge and moral responsibility to his son, which the son readily accepts as he echoes the numeric value *five* in the next turn. In this way, the son's repetition serves as a confirmation response, demonstrating alignment with his father's contribution. In terms of Goffman's (1981) production format, the father adopts the animator role, voicing what the son has seemingly principaled. So, while we can offer no claims as to why the father utters the pain level values that he does, or why he downgrades this value from *eight* to *five*, this short sequence nevertheless demonstrates how a family member willingly assumes responsibility and provides information on a topic and in a domain where he arguably has little epistemic access. However, his linguistic choices suggest a footing that is facilitative (rather than dominating or inappropriate), demonstrating his eagerness to speak *alongside* his son so that a complete health picture can be presented.

A final example from this medical encounter further illustrates the diverse contributions made by the father in this interaction. This sequence takes place at the end of the treatment discussion, as the attending physician continues the interactional work needed to convince the patient to continue with the topical cream treatment recommendation until she can run further diagnostic tests (Koenig, 2008, 2011; Stivers, 2006).

194:	ATT:	you're very sleepy an drowsy
195:	PAT:	no I would I would d- sleep an drowsy?
196:	ATT:	right now yeah
197:	PAT:	no I'm no- I
198:	PAT FAT:	**he has a I think gen- it's kinda a general malaise**
199:	ATT:	uhm uh
200:	PAT FAT:	that he he has
201:	ATT:	[but that's the point many of the medications give that as a
202:		side effect so tha- I would prefer him to use also something topical
203:		until we figure out what's going on
204:	PAT FAT:	uhm uh
205:	ATT:	because I don't want to medicate him an miss the opportunity to
206:		diagnose something really serious
207:	PAT:	well if could try it he we- he lives a mile like two miles from my
208:		house
209:	ATT:	[uhm uh
210:	PAT:	an he my he he we talk all the time an if there would be a problem
211:		with that then he would know about it uh uh
212:	PAT FAT:	**I'm what he's tryin ta say is that I monitor his pill intake an I**
213:		**fix em all up for him**
214:	ATT:	[uhm uh
215:	ATT:	yeah I cannot prescribe you opiates that's that's you know

As the sequence begins the attending physician reiterates her observation that the patient appears *very sleepy an drowsy* (line 194). Over the next few turns, the patient attempts to dispute this drowsiness claim (lines 195 and 197). Then in line 198 the father joins the conversation, providing his own description of his son's general condition. After a false start, he takes an epistemic stance (*I think*) to offer that his son has *a general malaise*. This contribution reformulates the attending physician's claim, serving as an alternative assessment to her original *sleepy* and *drowsy* observation. The father attempts to continue but is cut short as the attending physician interrupts him to provide a lengthy explanation for the patient's condition (*medications give that as a side effect*) and to justify her treatment recommendation (i.e., a topical pain reliever) and reasoning (*I don't want to medicate him an miss the opportunity*…).

In the next turn (lines 207–208), the patient shifts frames as he moves the conversation away from the medical realm and into the social and personal realm. He states that he lives in close proximity to his father and *we talk all the time*. Starting in line 212 the father joins the conversation to provide additional information. Again, he assumes a facilitative footing as he formulates the opening to his utterance (*what he's tryin ta say*) with a discursive device that serves to align with as well as contextualize his son's previous utterances. He continues by stating that *I monitor his pill intake an I fix em all up for him*. This pill monitoring contribution

not only provides additional information but it also serves to bridge the social and medical realms in a way that the son was not able to articulate on his own (otherwise, one might wonder why the patient is providing this personal information here). The attending physician chooses not to pursue this social line; rather, she refocuses the interaction, returning it to the medical realm as she assumes an authoritative footing to reiterate that she cannot prescribe opiates to the patient.[12]

These examples demonstrate that being "a father does not mean playing one 'role' but entails shifting between multiple frames and footings" (Gordon, 2015, 330). As we have shown, the father skillfully handles the shifting frames of this treatment advice phase as he provides information to both the physician and patient on a range of topics within the medical and social realms. We argue further that without the father's contributions valuable information would likely have not been provided, given that this patient was not always able to create a coherent account of his condition to the physicians. As a consequence, at times the father readily fills the conversational space as he paraphrases, clarifies, and expands on his son's utterances. These examples demonstrate how the father assumes a pseudo-surrogacy role (Mazer et al., 2014) as he not only speaks *alongside* his son but also speaks *on his behalf* (Beisecker, 1989; Coupland and Coupland, 2001). However, when speaking *on behalf of* his son to provide useful information (e.g., patient is not using a topical cream; the patient's pain level) his use of alignment strategies suggests that his pseudo-surrogate contributions were facilitative, as opposed to domineering. In this way, and in order to make up for some of his son's verbal lapses, the father positions himself as a legitimate contributor, sharing some of the medical knowledge responsibilities and authority in order to present a more comprehensive picture of his son's health and condition.

4. Discussion and conclusions

The aim of this study was to demonstrate, through a detailed analysis of medical encounter discourse, the ways in which family members make contributions in contexts and with patients whose health conditions, and cognitive and linguistic abilities did not — at least in any observable way — necessitate extra assistance from a family member or companion.[13] Other studies examining triadic or multi-party medical encounters have explored factors such as patient's current health status, age, and cognitive abilities to account for when and why companions participate in the medical encounter (Beisecker, 1989; Clayman et al., 2005; Tates et al., 2002). In this study we pursued an alternative perspective, by closely examining the linguistic and discursive strategies family members employed when they elected to verbally participate in the interaction.

We have expanded the multi-party medical encounter research by examining interactions in two medical specialties — Neurology and Rheumatology — with patients whose age ranged from 30s to 70s, and with health conditions ranging from chronic (e.g., arthritis) to nearly in remission. Within these non-geriatric and non-pediatric contexts, it was often the case that patients were able to speak for themselves, answering physicians' questions and providing essential details about their well-being. Therefore, an important contribution of this study was the demonstration of how family members established themselves as legitimate co-collaborates, speaking *alongside* patients as they facilitated, co-narrated, and filled in details of the patients' health picture.

As our data illustrated, speaking *alongside* was expectedly manifested in a variety of ways. Family members spoke *alongside* patients by working collaboratively to provide physicians with responses and information to support and aid decision-making. These contributions served as important cognitive resources used to recall, elaborate, and clarify details on a wide variety of topics. Speaking *alongside* patients, family members were provided the opportunity to not only reveal their impressions of a patient's condition but also to provide an alternative interpretation, and to potentially reframe the conversation to include behavioral and social factors in treatment decisions. Speaking *alongside* patients also meant that, at times, a family member's established legitimate voice challenged the delicate balance of expertise (Candlin and Candlin, 2002; Drew, 2001), denying the patient a voice and agency about decisions concerning treatment. Therefore, through these examples, in which patients were capable of speaking for themselves, we have illustrated some ways in which family members served the central function of speaking *alongside* patients, as well as physicians.

As discussed previously, the examination and categorization of companions' multiple roles during triadic interactions has been a primary theme discussed in previous research (Beisecker, 1989; Hasselkus, 1992; Ellingson, 2002). Our study added further nuance to this extant body of literature focusing on companions' various roles by providing discursive evidence demonstrating the ways in which companion roles were achieved and enacted. Drawing on the concepts of (re)framing and footing, and through a close examination of the variable linguistic and discursive strategies family members employed, our analysis has demonstrated how the diversity and fluidity of roles are achieved. Importantly, the analysis also showed that through the establishment of different footings, family members' utterances served to align and, at times, disalign (Extract 3.2) with the other participants. Therefore, this analysis illustrate how these different concepts (e.g., framing, footing, alignment) can shed additional light on the different discourse roles (Sarangi, 2010) that are taken up by participants in this type of medical multi-party talk.

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[12] Earlier in the medical encounter when the attending physician joins the interaction she immediately tells the patient that she will not write a prescription for opioids.

[13] As explained above, we acknowledge that the patient in Extract 3.3 was, at times, incoherent and silent during stretches of the interaction. However, with that said, he was able to speak for himself and indeed, did so on many occasions in the interaction. Several factors may contribute to and account for his erratic participation (e.g., medication, fatigue), however based on the first author's observations of the interaction, neither his cognitive nor linguistic abilities appeared to be otherwise impaired.

Our analysis also explored the ways in which family members displayed knowledge in the interactions. Drawing on the work of Stivers et al. (2011) on epistemic access, primacy, and responsibility, we have demonstrated how family members relied upon and utilized various epistemic resources in their interactions. For example, in Extract 3.1 the husband was able to draw on a "vast store of prior knowledge" (Hasselkus, 1992, 301) about his wife's health condition and medical history, displaying specific knowledge and contributing it at relevant times during the interaction. And while this extract illustrated how a family member participant displayed knowledge in relatively straightforward ways, Extract 3.3 demonstrated how a family member assumed greater epistemic responsibility providing information that served to present a more complete picture of his son's health and social wellbeing. Although we have explored the ways in which family members exercised their responsibility to display knowledge in a variety of domains, important questions remain unanswered and require further exploration. For instance, what ethical responsibility does a family member have to share valuable information about a patient during the interaction? What does a silent companion suggest? Who is responsible for addressing a family member's competing or contradictory displays of knowledge? The patient? The physician?

Our study and others (Coupland and Coupland, 2001; Karnieli-Miller et al., 2012; Laidsaar-Powell et al., 2013) have shown how the addition of a third (or fourth) person can add increasing complexity to an already challenging communicative event. Therefore, we join other scholars who argue that communication skills training for medical doctors and other healthcare professionals remains essential (e.g., Hasselkus, 1992; Karnieli-Miller et al., 2012). As demonstrated, a multi-party medical encounter demands advanced interactional skills as multiple participants use a variety of discourse strategies to share, and compete for the conversational floor to do the important work of "doctoring." Consequently, sustained educational training and instruction in a variety of formats — formal, informal, pamphlets, web-based — is required for medical doctors, as well as for patients and their family members.

Future research might explore the potential benefits that may be achieved when patients and family members discuss, in advance of the encounter, the role, level, or type of support (e.g., informational, emotional, practical) that the family member will provide during the interaction in order to meet the patient's needs. Agreement on, or minimally discussion about, the patient's needs and preferences can potentially aid in lessening confusion or patient-family member conflict during the interaction. Moreover, any insights that a physician can be provided ahead of time about a family member's optimal level of participation and type of support can potentially enhance communication between the participants and may ultimately lead to a more effective clinical encounter for the patient (Hasselkus, 1992).

Finally, there is clearly a need for additional empirical research on multi-party medical encounter talk that explores other medical specialties, beyond geriatric and pediatric settings (Ellingson, 2002; Halkowski, 2011), other clinical settings, or with different types of healthcare professionals (e.g., nurses, pharmacists). According to Wolff and Roter (2011), more than one in three (38%) routine medical visits across different specialties and age groups (compared to 29% in our dataset) are triadic, with a companion or family member accompanying the patient. This finding suggests that multi-party interactions occur frequently enough to warrant an expanded examination in different specialties. We acknowledge that a limitation of this study is its reliance on audio-recorded medical encounter interactions and thus recommend that future multi-party research incorporate the use of video. In so doing, a more nuanced analysis of the nonverbal behaviors and multimodal resources interactants use in conjunction with their verbal expressions can further inform this area of study. Continued exploration of multi-party medical encounter talk, in a greater variety of settings and employing different theoretical and methodological approaches, would contribute to a better understanding of these complex medical interactions.

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